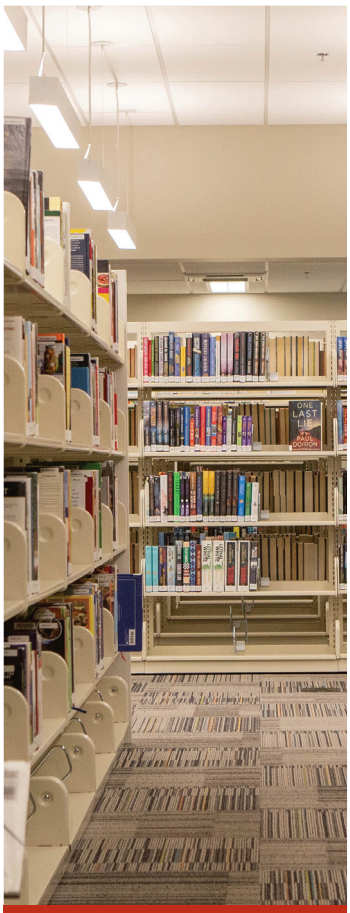
Baltimore County Government



2022 BENEFITS GUIDE

BaltimoreCountyMD.gov/Benefits

Table of Contents

The proceeding 2022 Benefits Guide maintains information on both Active Employees and Retirees. Previously, Active Employees and Retirees received distinct benefits guides. To streamline benefits information found within our guides and eliminate duplicate information, we present to you the 2022 Active and Retiree Benefits Guide.

The purpose of this Benefit Guide is to give you basic information about your benefit options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to the plan documents for important additional information about the plans.

Medicare Retirees

Retirees and/or spouses on Medicare will receive a separate benefits and enrollment guide from Labor First regarding their Medicare supplemental, advantage, and prescription options with Baltimore County. This guide applies to non-Medicare medical, dental, vision, and life insurance.

Baltimore County Government
Important Contacts

CONTACT:	REGARDING:
Active Employees / Retirees **Insurance Division, Office of Budget and Finance** 400 Washington Ave., Rm 111 Towson, MD 21204 **Phone: 410-887-2568 or 1-800-274-4302** **Fax: 410-887-3820** **MAIL STOP 2105** **Email: bcbenefits@baltimorecountymd.gov** **Internet: www.baltimorecountymd.gov/benefits**	■ General benefit questions ■ Benefit eligibility ■ Life status changes resulting in the addition to or removal of someone from your insurance plans ■ Life insurance ■ Dental and vision benefits ■ Baltimore County COBRA benefits ■ ESS Enrollment Wizard questions ■ New retiree benefits questions
Active Employees / Retirees **Baltimore County Retirement Office** 400 Washington Ave., Rm 169 Towson, MD 21204 **Phone: 410-887-8246 or 1-877-222-3741** **Email: ers@baltimorecountymd.gov**	■ Questions about your pension benefits ■ Retirement beneficiary changes and inquiries ■ Address changes or other Retirement Office file changes ■ Notify in event of divorce, marriage, or death of dependent spouse or beneficiary ■ Your intent to retire from Baltimore County
Active Employees **Baltimore County Pay Systems Administration** 400 Washington Ave., Rm. 169 Towson, MD 21204 **Phone: 410-887-2420**	■ Questions about your pay deductions ■ Changes to your tax withholding amounts ■ Changes to your direct deposit designation
Active Employees **Baltimore County Office of Human Resources** 308 Allegheny Ave Towson, MD 21204 **Phone: 410-887-3120** **Fax: 410-887-6073** **MAIL STOP 62**	■ Attendance, absence, and leave procedures ■ Classification and compensation ■ FMLA (Family and Medical Leave Act) ■ Leaves of Absence

Baltimore County Government
Important Contacts

CONTACT:	REGARDING:
MEDICARE RETIREES ONLY **Labor First, LLC** 3000 Midlantic Drive, Suite 101 Mount Laurel, NJ 08054 **Phone: 410-431-2226 or Toll Free 855-499-2656** **Email: Members@laborfirst.com** **Internet: www.laborfirst.com**	■ Medicare medical and prescription plan questions ■ Assistance with enrolling in County Medicare medical/rx plans ■ County Medicare retiree plan materials ■ Provider eligibility assistance ■ Precription copay estimates ■ Pharmacy network questions
ACTIVE EMPLOYEES / NON MEDICARE RETIREES **Baltimore County Employee Assistance Program** **(Administered by Cigna Behavioral Health)** **Phone: 888-431-4334** **www.myCigna.com (password: baltimore)**	■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues
Social Security Administration (SSA) **Phone: 800-772-1213** **Internet: www.ssa.gov**	■ Change of address ■ General Medicare Part A or B eligibility or premiums
Medicare Help Line **Phone: 1-800-MEDICARE (633-4227)** **Internet: www.medicare.gov**	■ Request new ID card ■ Ordering Medicare publications ■ General Medicare information

Active Employee Enrollment and Eligibility Guidelines

Open Enrollment Information

The Open Enrollment period begins on October 15th and ends on November 12th. Benefit changes and FSA re-enrollment must be completed online at **www.baltimorecountymd.gov/mybenefits** by November 12, 2021. Changes will be effective January 1, 2022.

Health Insurance Eligibility

Medical, dental, and vision insurance are available to all employees. Those working 30+ hours per week receive the highest County subsidy, the amount Baltimore County pays towards an employee's insurance premiums. Part-time employees, those working 26-29 hours per week, are eligible for medical, dental, and vision benefits at a reduced subsidy. Part-time employees working less than 26 hours per week are eligible for medical, dental, and vision benefits but with no subsidy from Baltimore County and, in turn, will pay 100% of the cost of their insurance premiums.

Should an employee's regular paycheck not cover the cost of coverage, the employee may not elect those benefits. An employee may elect medical, dental, and/or vision benefits separately from one another. Enrollment in one does not require enrollment in the other(s).

Please view rate sheets at **www.baltimorecountymd.gov/benefits** for specific premium costs.

Life Insurance Eligibility

Life Insurance is available to employees working at least 30 hours per week.

Dependent Eligibility

- **Spouse** (opposite and same sex marriage must be legally recognized)
- **Dependent child** up to the end of the month in which they reach age 26, regardless of whether the dependent is married, a student or non-student, residing at home or residing outside the home **and who is:**
  - The employee or spouse's child by birth or legal adoption recognized under Maryland law
  - A child under testamentary or court appointed guardianship recognized under Maryland law who resides with the employee or spouse
  - A child who is the subject of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

Eligible dependents are required to have legal standing and/or legally sufficient documentation for residency in the United States while included on County health plans.

Including your dependent(s) on County benefits plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

Changes During Open Enrollment

Examples of changes you may need to make during Open Enrollment include:

- Adding or removing a dependent if you did not do so within the first 31 days of the qualifying event. Proof of dependent eligibility may be required.
- Enrolling or changing Medical, Dental or Vision Coverage
- Renewing or starting a Flexible Spending Account

New Hires

Newly hired employees have 31 days to enroll in all benefits. To enroll in Medical, Dental, Vision, and Flexible Spending Accounts go to **www.baltimorecountymd.gov/mybenefits** and log in to ESS. Process your benefits selections through the ESS Enrollment Wizard. Benefits will be effective the first of the month following the completion of the online enrollment process.

To enroll in Additional Life, Spouse Life, Child Life, Cigna Voluntary Long-Term Disability insurance, or Commuter Choice Parking and Transit accounts, please visit **www.baltimorecountymd.gov/mybenefits** and log in to Benefit Solver. New hires will have 31 days from their date of hire to elect additional life insurance benefits without Evidence of Insurability.

Deduction Frequency

Active employees pay for benefits in the month in which they are covered on a biweekly (every pay) frequency. The 3rd pay cycle of any given month will have insurance deductions.

Example: Deductions from January's paychecks pay for January's insurance coverage

IMPORTANT NOTE:

For Active Employees reaching the age of 65 and/or Medicare eligibility:
As long as you are enrolled in one of Baltimore County's group medical insurance plans, you can delay your Medicare Part B enrollment until your retirement from Baltimore County, no matter what age that they occur. This will also apply to your legal spouse as long as they are also covered by our County group medical plan. Part A, Medicare's hospital insurance, is typically premium-free and an employee can choose whether to accept it or not. Once you initiate your plans to retire, Baltimore County will provide you with the necessary documentation waiving any penalty involved with late Medicare enrollment. You and your spouse, if applicable, will enroll in Medicare at the time of retirement. This arrangement allows for and encourages working beyond the age of 65 to still maintain active County benefits. This may be cost effective for the employee and their spouse as well as more convenient and familiar.

Active Employee Enrollment and Eligibility Guidelines
Changes During the Year

Basic Rules of Baltimore County's Benefits Program

Baltimore County's Benefits Program allows you to choose the benefits you need while providing important tax advantages to County employees and to the County. Your share of the cost for your benefits is paid with pre-tax payroll deductions. This means that employee payroll deductions for benefits are not subject to State, Federal and O.A.S.D.I. taxes.

In order to maintain this favorable tax treatment, the Internal Revenue Service (IRS) has established rules that govern our Benefit Program operation. **Most important, the IRS requires that the choices you make remain in effect for 12 months unless you have a qualifying lifestyle change.**

Qualifying family status changes include marriage, legal separation or divorce, birth or adoption, or changes to your (or your spouse's) other benefit coverage related to changes in employment status. Significant changes to benefit costs or coverage made by an employer providing other coverage may also qualify.

If you experience a qualifying family status change, any change you make to your benefits must be "on account of and consistent with the lifestyle change." For example, if you get married or have a child, you can add your new dependent to your plan and change the plan you chose during open enrollment.

Family Status Changes

It is your responsibility to notify the Insurance Division within 31 days each time you have a change in your family status. Examples include:

- Birth or adoption – children must be added to your coverage within 31 days of birth or adoption.
- Marriage, Divorce or Legal Separation
- Loss of dependent child status – child is reaching age 26
- Loss or gain of other coverage due to a change in employment status (i.e. changing from full-time to part-time status)
- You move to a new residence outside Maryland that is not included in your current plan's coverage area.
- If you or your dependents become eligible for Medicare.

You must provide proof of the change requested (i.e. a copy of the divorce decree to remove a spouse from coverage, or copy of birth certificate to add newborn.). Changes to benefits will be effective the first of the month after the Insurance Division receives your change request and requested documentation.

Including your dependent(s) on County benefit plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

Continuation of Coverage While on an Approved Leave of Absence

If you are on an approved leave of absence from Baltimore County, your health plan contributions will continue to be deducted from your paycheck as long as you have paid leave (i.e., sick leave, vacation, holiday, etc.) available. When your accrued leave is exhausted or when you cease to be paid by Baltimore County, you must contact the County Insurance Division to make arrangements to continue your benefits.

Notice of HIPAA Special Enrollment Rights (Health Insurance Portability and Accountability Act)

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in a County benefit plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Retired Employee Enrollment and Eligibility Guidelines

Open Enrollment Information

Benefits change requests for all non-Medicare plans, including dental and vision must be received by 11/12/2021. Enrollment changes will be effective 1/1/2022.

Eligibility

- Minimum 10 years creditable years of Baltimore County service(Those retired prior to 7/1/2006 must have 5 years)
- Must be receiving a pension check large enough to cover the retiree's share of insurance premiums

30 Year Exception

- Employees that did not contribute to the Baltimore County Employee's Retirement System and are receiving no County pension check may feel like they lost out on both County insurance and County pension benefits. However, those employees with more than 30 years of service may participate in eligible County group plans at no subsidy when they retire even though they did not participate in the County ERS. All of our plan offering are open to this group but at 100% of the cost. Please contact the Insurance Division with any questions.

Dependent Eligibility

- **Spouse** (opposite and same sex marriage must be legally recognized)
- **Dependent child** up to the end of the month in which they reach age 26, regardless of whether the dependent is married, a student or non-student, residing at home or residing outside the home **and who is:**
  - The retiree or spouse's child by birth or legal adoption recognized under Maryland law
  - A child under testamentary or court appointed guardianship recognized under Maryland law who resides with the employee or spouse
  - A child who is the subject of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

Eligible dependents are required to have legal standing and/or legally sufficient documentation for residency in the United States while included on County health plans.

Including your dependent(s) on County benefit plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

Medicare Retirees Eligibility (Due to Age or Disability)

Baltimore County requires that as soon as a retiree or spouse of a retiree is eligible for Medicare due to age or disability, that they accept Medicare as their primary health insurance. It is very important to obtain both Part A (Hospital) and Part B (Medical) of Medicare. Typically, Medicare becomes effective the first day of the month in which you reach age 65 or otherwise become eligible due to disability. For additional information regarding Medicare, please contact Social Security.

Once enrolled in Medicare, you or your spouse, will be eligible to enroll in a Medicare Advantage, Medicare Supplemental and/or Part D Prescription plan offered through Labor First. Please notify Labor First at (410) 431-2226 as soon as you are enrolled in Medicare to discuss your Medical and Prescription plan options. Dental and Vision enrollments will still be administered by Baltimore County Government.

What If My Spouse or I are Not Eligible for Medicare?

You may not be eligible for Medicare if you did not work the required number of quarters required by the Social Security Administration. If you do not qualify on your own, you may qualify for spousal coverage. You will need to contact your local Social Security office to determine whether you can enroll in Medicare. Those few retirees turning 65 but not eligible for Medicare either on their own or through a spouse will be required to provide documentation to the Insurance Division indicating their lack of eligibility. Please contact the Insurance Division with any questions if this applies to you.

What if I Become Eligible for Medicare but My Spouse is Not Yet Eligible?

You, as the retiree, will select one of the many options afforded to you through our partnership with Labor First and transition to Medicare. Your spouse can continue on their current plan until they are then eligible for Medicare. Note that you will now pay for Individual coverage for both yourself and your spouse from your pension check. Once on Medicare, these deductions will continue to be itemized separately on your pension check.

Widow and Widower Eligibility

Depending on the option chosen at the time of retirement and the classification of the retiree, health plan benefits may be available to a widow/widower with a subsidy from Baltimore County. For this reason, it is very important to give a great deal of consideration to your retirement option at the time you elect to retire.

Widow/widower plan costs will be based on the date of retirement and the retiree's creditable years of service. The widow/widower must be receiving a pension check sufficient to cover their share of the health plan premium deductions. If you choose a pension option that will not provide payments sufficient to cover benefits for your spouse upon your death, your spouse will not be eligible for County subsidized benefits.

Baltimore County will subsidize the cost of coverage for a widow/widower whose spouse was killed in the line of duty at the same level as active employees.

If a widow/widower remarries, the new spouse is not eligible for coverage under a County sponsored health plan. Widow/widowers not receiving a pension amount sufficient to cover benefits would be eligible for 36 months of COBRA coverage if necessary. COBRA coverage is not subsidized by the County and requires that the participant pay 102% of the actual plan premium.

Changes During the Year

It is your responsibility to notify the Insurance Office within 31 days each time you have a change in your Family Status. You must provide proof of the change requested (i.e. – a copy of the divorce decree, separation agreement to remove a spouse from coverage, or copy of birth certificate to add newborn.) Changes to benefits will be effective the 1st of the month after the Insurance Division receives your change request and appropriate documentation.

Contact the County Insurance Division at **410-887-2568** or **1-800-274-4302** if any of the information on your benefit records changes. Examples include:

- Birth or adoption of a new child - children must be added within 31 days of birth
- Marriage, Divorce, Legal Separation
- Loss or gain of other insurance coverage
- Moving residences outside of your plan's coverage area. This mainly refers to Kaiser insurance products.

Medicare Retirees

Contact Labor First at **410-431-2226** regarding any of the above changes.

Changes During Open Enrollment

Examples of changes you may need to make during Open Enrollment include:

- Adding or removing a dependent if you did not do so within first 31 days of the qualifying event
- Changing the medical, dental or other plans you currently have

COBRA Coverage When Employment Ends

NOTE
This does not apply to those retiring with benefits from Baltimore County.

Continuing Coverage After Employment Ends

COBRA stands for Consolidated Omnibus Budget Reconciliation Act. It's a federal law that was created in 1985 that gives individuals who experience a job loss or other qualifying event the option to continue their current health insurance coverage for a limited amount of time.

Opting for COBRA will allow you to stay on County benefits. However, you will pay 100% of the monthly premium cost plus an additional 2% administrative charge.

Each individual who is covered by a Baltimore County health plan immediately preceding the employee's COBRA event has independent election rights to continue his or her medical, dental, vision or Health Care Spending Account. The right to continuation of coverage ends at the earliest of when:

- you, your spouse or dependents become covered under another group health plan; or,
- you become entitled to Medicare; or,
- you fail to pay the cost of coverage.

You must notify Baltimore County's Insurance Division within 31 days of the following COBRA events:

- divorce or legal separation
- death of an employee
- dependent child's loss of dependent status

A Quick Look at Your COBRA Continuation Rights	Maximum COBRA Continuation		
Loss of Coverage is Due to...	For You	For Your Covered Spouse	For Your Covered Children
Your employment ending for any reason (except gross misconduct) or your hours are reduced so you are no longer eligible for medical, dental vision, and the health care spending account	18 months	18 months	18 months
You or your covered spouse or dependent is disabled (as determined by Social Security Administration) at the time of the qualifying event, or becomes disabled during the first 60 days of COBRA continuation	29 months	29 months	29 months
Your death	—	36 months	36 months
Your divorce or legal separation	—	36 months	36 months
You become entitled to Medicare	—	36 months	36 months
Your covered child no longer qualifies as a dependent	—	—	36 months

Cigna Employee Assistance Program (EAP)
Active Employees and non-Medicare Retirees

Baltimore County's EAP services are administered by Cigna. They are available to County employees working 26+ hours per week, non-Medicare retirees, and their household members. Cigna EAP is available 24 hours a day, seven days a week, at **1-888-431-4334**.

Cigna EAP can also be accessed at **www.myCigna.com** employer id: **baltimore**

Commitment to Superior Mental Health and Work / Life Services

Baltimore County acknowledges that the success of any County program relies heavily upon the well-being and commitment of current and former County employees. In order to support a healthy and productive workplace, the County has worked with Cigna to develop an integrated employee assistance and work / life support program. These services have been designed to meet employee and non-Medicare retiree needs. They are of and conform to the highest standards of quality.

Using your Baltimore County Employee Assistance Program

Baltimore County eligible employees, non-Medicare retirees, and their household members have access to the EAP program. Household members can be related or unrelated. EAP can help you or a household member in need of assistance, with a wide variety of problems or concerns. EAP provides telephonic consultation, face to face counseling (up to 10 visits with a local EAP provider) per issue, per year, for every household member of a Baltimore County employee or non-Medicare retiree. EAP services are not tied to your selection of a County health plan. There is no charge for EAP service. For more information, please contact Cigna EAP at **1-888-431-4334**.

If EAP is not the best setting for your care, you will be assisted with obtaining Managed Mental Health Benefits, available to you, through your County-sponsored health plan.

Work / Life Assistance

County employees and non-Medicare retiree's work and home lives are impacted by their personal well-being. Through the EAP program, work / life support services are available.

Child care, elder care and pet care referral services

Whether an employee or non-Medicare retiree is seeking assistance with finding an in home daycare, a nanny, or a daycare center, summer camps, an adult daycare setting, or a pet sitter, etc Cigna EAP can assist with finding child care, elder care or pet care services that meet the particular needs of employees. By calling Cigna EAP at **1-888-431-4334**, and asking to speak with a work/life specialist, Baltimore County employees, non-Medicare retirees, and their household members can receive assistance with finding pre-screened referrals for a variety of work / life needs.

Legal and Identity Theft

Those concerned with personal legal problems may be distracted both at work and at home. It can be difficult to manage those issues without legal assistance. Baltimore County employees and their household members can consult with an attorney, for 30 minutes, at no cost. This consultation can occur in person, or via the telephone, and includes consult for a wide range of legal concerns, with the exception of employment law.

In addition, they may receive 60 minutes of telephonic support with a fraud resolution specialist, at no cost. Legal and identity theft consultation can be obtained by calling Cigna EAP at **1-888-431-4334**.

Financial Consultation

Financial issues touch the life of every individual. Without the appropriate information or knowledge, these issues can become time-consuming and stressful, affecting productivity. Cigna EAP's Financial Consultants can assist you with the following financial matters, during a free 30 minute telephonic consultation:

- Managing Personal and Financial Challenges
- Credit Card and Debt Management
- Budgeting
- Tax Questions
- Financing for college
- Investment options
- Mortgage, loans, and refinancing
- Retirement planning
- Estate planning
- And more

Get the help you need

Call Cigna EAP 24 hours a day, seven days a week, at the toll free number listed below. You will be connected to a Personal Advocate, who will talk with you about your specific situation, and the resources available to you, at no cost, through your EAP program.

Cigna Employee Assistance Program
Call: **1-888-431-4334**
Go online: **www.myCigna.com**
Your Employer ID: **baltimore**

Cigna Open Access Plus (OAP)
Active Employees and non-Medicare Retirees

With the Open Access Plus plan (OAP), you get choice. So, each time you need care, you choose the doctor or facility that works best for you.

Options for Care

- **Primary Care Physician (PCP)** – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network** – Choose to see doctors or other health professionals who are in the Cigna network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care** – If you need to see a specialist, you don't need a referral.

  You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Cigna Care Designation** – Cigna evaluates in-network providers in the most common specialties. Only those who meet Cigna standards for both quality and cost efficiency receive the Cigna Care Designation.
- **Cigna Centers of Excellence** – Cigna identifies hospitals as Centers of Excellence when they achieve the highest performance in both health outcomes and savings.
- **Out-of-network** – You have the freedom to see doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.
- **Emergency and urgent care** – When you need care, you have coverage.
- **24/7 service** – Whenever you need us, customer service representatives are available to take your call: 1-800-896-0948.

Predictable out-of-pocket costs – Depending on your plan, you may have to pay an annual deductible before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for covered services. Then, the plan pays the rest. If you receive out-of-network care, providers may bill you for charges that are more than what your plan pays for covered expenses.

Once you reach your out-of-pocket maximum, the health plan pays your covered health care costs at 100%.

Cigna Virtual Care

With virtual care you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Virtual care is designed to handle **minor nonemergency medical** and **behavioral support**. Virtual care allows you talk privately with a licensed counselor, psychiatrics or board-certified doctor via video or phone. Wellness screenings are also now available through MDLive.

To find a **Cigna Behavioral Provider** that best fits your needs, follow these steps:

1. Login to **myCigna.com**
2. Click on "connect now" to speak to someone right away or to schedule an appointment
3. Under Counseling, click on "Connect"
4. Select the health topic you would like your provider to have experience in or use the arrow to view more options and then press "Continue"
5. Once you decide which program you would like to participate in, select the "connect" button to schedule an appointment

You may be asked to enter your medical ID number to verify benefits and credit card information to pay for any copays or co-insurance, if applicable.

▪ Visit ▪
MDLIVEforCigna.com
(888) 726-3171

Cigna Open Access Plus In-Network (OAPIN)
Active Employees and non-Medicare Retirees

With the Open Access Plus In-network plan, you get access to a large network of health care professionals and facilities. So, each time you need care, you choose the in-network doctor or facility that works best for you.

Enroll in the Open Access Plus In-network plan and get these options for care:

- **Primary Care Physician (PCP)** – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network** – For your health care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.
- **No-referral specialist care** – If you need to see a specialist, you don't need a referral to see an in-network doctor.

  You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Cigna Care Designation** – Cigna evaluates in-network providers in the most common specialties. Only those who meet Cigna standards for both quality and cost efficiency receive the Cigna Care Designation.
- **Cigna Centers of Excellence** – Cigna identifies hospitals as Centers of Excellence when they achieve the highest performance in both health outcomes and savings.
- **Out-of-network** – If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.
- **Emergency and urgent care** – When you need care, you have coverage.
- **24/7 service** – Whenever you need us, customer service representatives will take your call – 1-800-896-0948.

Cigna Virtual Care

With virtual care you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Virtual care is designed to handle **minor nonemergency medical** and **behavioral support**. Virtual care allows you talk privately with a licensed counselor, psychiatrics or board-certified doctor via video or phone. Wellness screenings are also now available through MDLive.

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5. Once you decide which program you would like to participate in, select the "connect" button to schedule an appointment

You may be asked to enter your medical ID number to verify benefits and credit card information to pay for any copays or co-insurance, if applicable.

▪ Visit ▪
MDLIVEforCigna.com
(888) 726-3171

Cigna High Deductible Health Plan (HDHP)
Active Employees and non-Medicare Retirees

In partnership with Cigna and Benefit Strategies, Baltimore County will be offers a high deductible health plan (HDHP) that can be combined with a health savings account (HSA). The Cigna High Deductible Health Plan (HDHP) can help you take control of your health and your costs.

Options for Care

- **Primary Care Physician (PCP) –** You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network –** Choose to see doctors or other health professionals who are in the Cigna network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care –** If you need to see a specialist, you don't need a referral. You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Cigna Care Designation** – Cigna evaluates in-network providers in the most common specialties. Only those who meet Cigna standards for both quality and cost efficiency receive the Cigna Care Designation.
- **Cigna Centers of Excellence** – Cigna identifies hospitals as Centers of Excellence when they achieve the highest performance in both health outcomes and savings.
- **Out-of-network –** You have the freedom to see doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.
- **Emergency and urgent care –** When you need care, you have coverage.
- **24/7 service –** Whenever you need us, customer service representatives are available to take your call: 1-800-896-0948.

Helpful HDHP Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent.

The pros and cons of an HDHP

Pros

Lower monthly premium/plan contribution – If you anticipate only needing preventive care, then the lower premiums/plan contributions that often come with a HDHP may help you save money in the long run.

Tax-advantaged spending account – The Cigna HDHP can be paired with a Health Savings Account (HSA) through Benefit Strategies, LLC to help pay for eligible medical expenses.

Cons

Higher deductible – You are required to pay for your medical care out-of-pocket up to your deductible amount before your health plan begins to help pay for covered costs.

Costly out-of-pocket medical expenses – If you need non-preventive medical

Cigna Virtual Care

With virtual care you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Virtual care is designed to handle **minor nonemergency medical** and **behavioral support**. Virtual care allows you talk privately with a licensed counselor, psychiatrics or board-certified doctor via video or phone. Wellness screenings are also now available through MDLive.

To find a **Cigna Behavioral Provider** that best fits your needs, follow these steps:

1. Login to **myCigna.com**
2. Click on "connect now" to speak to someone right away or to schedule an appointment
3. Under Counseling, click on "Connect"
4. Select the health topic you would like your provider to have experience in or use the arrow to view more options and then press "Continue"
5. Once you decide which program you would like to participate in, select the "connect" button to schedule an appointment

You may be asked to enter your medical ID number to verify benefits and credit card information to pay for any copays or co-insurance, if applicable.

▪ Visit ▪

MDLIVEforCigna.com

(888) 726-3171

Health Savings Account (HSA)
Active Employees and non-Medicare Retirees

Baltimore County is pleased to announce that, effective 1/1/2022, employees and non-Medicare Retirees enrolled in the Cigna High Deductible Health Plan (HDHP) will receive a yearly County contribution regardless of their own contribution to an HSA account. Employees enrolled in the Cigna High Deductible Health Plan (HDHP) will now receive the below County contribution to their HSA account.

- $500/individual per year
- $1000/Family per year

This amount will be provided up-front at the beginning of each calendar year for those currently enrolled in the Cigna HDHP. Employees newly enrolling will receive the full year's contribution at inception of the employee's HDHP enrollment regardless of when that enrollment begins in the calendar year.

HSA contributions can only be made if you are enrolled in the Cigna High Deductible Health Plan (HDHP).

An HSA is an individual financial account, fully owned by you in the same manner as a personal bank account. Tax free payroll contributions can be made to an HSA when you are enrolled in the Cigna High Deductible Health Plan (HDHP). The money in your account remains yours even if you change employer or retire, and funds remain in the account until you spend them-there is no deadline to spend HSA funds. A Health Savings Account (HSA) allows you to pay for out-of-pocket healthcare expenses with pre-tax dollars, provides a triple-tax advantage and is a method to save for future healthcare expenses. **Triple Tax Advantage**: Contributions, earnings, and qualified distributions are tax free.

Eligibility requirements

- You must be a United States resident and work and pay taxes in the U.S.
- You cannot be enrolled in a non-HSA qualified medical plan, including Health FSA (although you can be enrolled in a Limited Purpose FSA for dental and vision expenses only)
- If you are married, your spouse cannot be enrolled in a Health FSA, but his/her enrollment in a Limited Purpose FSA is permitted
- You cannot qualify as someone else's tax dependent
- You cannot be enrolled in Medicare*

* There are typically triggers that result in automatic enrollment in Medicare Part A (such as collecting Social Security benefits at age 65 or older). Prior to one of these triggers, you should consult with the Social Security Administration on your Medicare Part A enrollment and effective date as it will impact your eligibility to make contributions to an HSA.

Our Banking Partner

Once your HSA enrollment is processed by Benefit Strategies, your enrollment information will be forwarded to our banking partner, Healthcare Bank (member FDIC), to establish your account. Healthcare Bank is a division of Bell Bank, one of the Midwest's largest banks Benefit Strategies HSA administration is fully integrated with your account at Healthcare Bank. You will have convenient and secure account access through your personal login at benstrat.com and through the Benefit Strategies mobile application. HSA funds are held in an interest-bearing cash account. You can set your account so that funds automatically move to investments once your cash account balance has reached a certain threshold. Your investment earnings, like interest earned in your cash account, grows tax-free! You can find information on current investment options in the HSA resource section at benstrat.com/resources-forms.

Making Contributions

Active Employees contributions will be made through a payroll deduction on a pre-tax basis (Federal, FICA and State taxes). You can also make direct contributions to your HSA on a post-tax basis and take the tax break when you file your taxes (although you will not have the FICA tax savings as you do with payroll contributions). Non-Medicare Retirees should contact Benefit Strategies directly to set up their HSA.

You need to stay within the annual contribution maximums established by the IRS. For 2022, the maximum contribution limits for HSA are:

- Single: $3,650
- Family: $7,300
- Those 55 and older can contribute an additional $1,000

Qualified HSA Expenses

HSA funds can be used to pay for qualified expenses for yourself, your legally married spouse and your tax dependents*. Qualified expenses include not only the out-of-pocket expenses you incur under your HSA qualified HDHP, but many other medical, dental and vision expenses. You can even use HSA funds to pay for certain medical plan premiums in retirement. For a list of HSA-eligible expenses, visit the HSA section at **benstrat.com** or view IRS Publication 502, published annually.

* Definition of HSA-eligible dependents may be different than the definition of eligible dependents on you medical plan.

Using Your HSA Funds

Although there are regulations governing when contributions can be made to your HSA, there are no regulations on when you can spend your HSA funds. Because the funds in your HSA are owned by you, they can be used at anytime, even after you are no longer enrolled in a HSA-qualified HDHP

Be sure to keep all receipts for HSA transactions with your other important tax documents. Funds held in the cash account are available immediately when you swipe your card or request a distribution. For invested funds, you will need to request a distribution through your secure online account, the mobile app, or complete and submit a distribution form. Typical turn-around time for disbursements from invested funds is 5-7 business days.

Managing Your Account

Through your secure online account at benstrat.com, and through the Benefit Strategies will contact all employees enrolled in an HSA account to notify them of account setup instructions and guidelines.

Have Questions?

Toll Free: 888-401-3539
Email: info@benstrat.com
Online Chat: benstrat.com

Cigna OAP/OAPIN/HDHP Prescription Drug Coverage
Active Employees and non-Medicare Retirees

With Cigna's pharmacy benefit, you'll be able to receive phone and online support.

The prescription program covers most medications which require a prescription by either State or Federal law and are prescribed by a licensed practitioner.

Prescription Drug List
Cigna's Prescription Drug List (PDL) is an extensive listing of generic and brand name prescription medications. Your pharmacy plan covers the cost of medications on the PDL – all you have to pay is your plan's copays.

Your PDL splits medications into three categories, or tiers:

- 1st Tier, Generic Medications:
  Generics have similar strength and active ingredients as their brand name counterparts. You will usually pay less for generic medications.
- 2nd Tier, Preferred Brand Medications:
  These medications will usually cost more than a generic, but may cost less than a non-preferred brand.
- 3rd Tier, Non-Preferred Brand Medications:
  Non-preferred brands generally have generic alternatives and/or one or more preferred brand options within the same drug class. You will usually pay more for non-preferred medications.

Acute Medications
For prescription drugs needed for shorter-term needs such as antibiotics, the plan allows for a 34-day supply per copay up to a maximum 102-day supply with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply.

Maintenance Medications
For prescription drugs needed on an on-going (sometimes daily basis), the plan allows for a 102-day supply of maintenance medication with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply. Mail order prescriptions require two copays for up to 102 day supply.

Home Delivery Service is for prescription drugs needed on a daily basis, like high blood pressure or cholesterol medications. These are delivered directly to your home mail box. This also saves you money; for a 3 month supply you will pay a 2 month copay.

Express Scripts Pharmacy is Cigna's home delivery pharmacy. As part of the first fill of a prescription through Express Scripts Pharmacy, members will need to provide payment information by phone with a Cigna representative or via the myCigna app or website. For assistance call **1-800-896-0948.**

Your Pharmacy Plan
You can:

1. Search our list of over 62,000 retail network pharmacies to find a pharmacy near you. If you are on the go and want to access our list on your smartphone, it is GPS accessible which means that we can help you find a pharmacy nearest to you.
2. See your pharmacy claim history, plan details and account balances and compare real-time drug prices at local retail pharmacies and Express Scripts home delivery. Pricing is shown specifically for your pharmacy plan. The prescription drug price quote tool is also designed to work easily on your smartphone for use on the go.
3. See a complete list of covered prescription drugs and see the category under which they are covered.

Specialty Pharmacy
Managing a complex medical condition isn't easy. The Accredo team of specialty-trained pharmacists and nurses will provide you with the personalized care and support you need to manage your therapy. Accredo will help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

To manage your specialty medication Log in to the myCigna® app or website.
Click on the Prescriptions tab and select Manage Prescriptions. Then click the button next to your medication's name. We'll automatically connect you to your Accredo online account portal.

Payment Assistance
If you're having trouble paying for your medication, Express Scripts Pharmacy offers an Extended Payment Plan, which gives you the option to split your bill into smaller payments.

Cigna OAP/OAPIN/HDHP Prescription Drug Coverage (continued)
Active Employees and non-Medicare Retirees

Step Therapy
Step Therapy is a prior authorized program which means that certain medications need approval before they are covered. In Step Therapy you and your doctor follow a series of steps when choosing your medication. Step Therapy encourages you to try the most cost-effective and appropriate medications available to treat your condition. Typically, these medications are generics or low cost brands. You need to try these first before more expensive medications are approved.

When you fill a prescription for a Step Therapy medication, we'll send you and your doctor a letter explaining what steps you need to take before you refill your medication. This may include trying a generic or lower cost alternative, or asking Cigna for authorization for coverage of your medication. At any time, if your doctor feels a different medication isn't right for you due to medical reasons, he/she can request authorization for continued coverage of a Step Therapy medication.

How myCigna.com helps you make the most of your pharmacy plan
You can:

1. Search our list of over 62,000 retail network pharmacies to find a pharmacy near you. If you are on the go and want to access our list on your smartphone, it is GPS accessible which means that we can help you find a pharmacy nearest to you.
2. See your pharmacy claim history, plan details and account balances.
3. Use the prescription drug price quote tool to see and compare real-time drug prices at local retail pharmacies and Express Scripts home delivery. Pricing is shown specifically for your pharmacy plan. The prescription drug price quote tool is also designed to work easily on your smartphone for use on the go.
4. See a complete list of covered prescription drugs and see the category under which they are covered.

Use the"Price a Medication" feature on the myCigna App today.

Download on the App Store | GET IT ON Google Play

Prior Authorization
Some prescription medications require a Prior Authorization review in certain situations before being covered. Prior Authorization verifies that a medication is appropriate for the diagnosis, dosage, frequency and duration of therapy. To initiate a request, have your doctor contact Cigna Pharmacy at 1-877-530-4437.

Supplemental Discount Program
Your plan includes the Supplemental Discount Program, which offers discounts on select prescription medications that your plan excludes from coverage. You don't need to sign up and there's no cost to participate. All you need to do is use your Cigna ID when filling your prescription. The pharmacist will review a discounted cash price with you. If it works for you, you'll just pay the pharmacy directly.

SaveonSP Program for OAP and OAPIN plans ONLY
Effective 1/1/2022. Enroll in **SaveonSP** and pay $0 copay for select specialty medications and there's no cost to participate.

Certain specialty medications are eligible for the SaveonSP program. If you're filling an eligible medication, a representative from SaveonSP will call you to talk about enrolling in the program.

If you choose to participate, you'll pay $0 for your medication. If you choose not to participate in SaveonSP, you'll pay a higher copay when you fill your medication.

Conditions supported by SaveonSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis
- Oncology

For additional information call Cigna pharmacy customer service.

Cigna OAP/OAPIN/HDHP Frequently Asked Questions

Active Employees and non-Medicare Retirees

How do I find out if my doctor is in the Cigna network before I enroll?

Our dedicated **Enrollment Information Line** is available 24/7 to help you learn about the benefits and advantages of Cigna. Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating providers. Call **1-800-896-0948**.

Do I have to choose a Primary Care Physician?

No. However, a PCP gives you and your covered family members a valuable resource and can be a personal health advocate.

Do I need a referral to see a specialist?

No. Though you may want your personal doctor's advice and assistance in arranging care with a specialist, you do not need a referral to see a participating specialist.

How does my plan cover my care?

When you visit a doctor who participates in the Cigna network, you receive in-network coverage. Participating health care providers have agreed to charge lower fees, and your plan covers a share of the charges. If enrolled in the OAPIN plan and you choose to visit a doctor outside of the network, your care will not be covered by your plan.

What if I need to be admitted to the hospital?

In an emergency, your care is covered. Requests for non-emergency hospital stays other than maternity stays must be approved in advance or "pre-certified." This enables Cigna to determine if the services are covered.

Precertification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for caesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining precertification?

Your doctor will help you decide which procedures require inpatient care and which can be handled on an outpatient basis. If your doctor participates in the Cigna network, he or she will arrange for precertification. Your plan materials will identify which procedures require precertification.

What is Case Management?

Case management is a program that assists customers with the hardships of an illness. A nurse Case Manager will help to coordinate the most appropriate care and works with you, your family and your physicians for the best results.

What if I go to an out-of-network physician who sends me to a network hospital? Will I pay in-network or out-of-network charges for my hospitalization?

Cigna will cover authorized medical services provided by an Open Access Plus participating hospital at your in-network benefits level—whether you were sent there by an in- or out-of-network doctor.

Why would Cigna call me?

Your employer offers you Cigna programs to help you get healthy and live well. When we call, we want to start a conversation so we can learn what's important to you – whether that's a chronic condition, making healthy choices, or filling a prescription. You may also be eligible for incentives for your participation. Every phone call is private and confidential.

Can Express Scripts Pharmacy help transfer my current prescription from my local retail pharmacy?

Yes. Simply call 800.835.3784 and have your doctor's contact information and prescription medication name(s) and dosage(s) ready. Express Scripts Pharmacy will do the rest.

Cigna OAP/OAPIN/HDHP Resources and Programs

Active Employees and non-Medicare Retirees

Personalized Website: myCigna.com

Life can be busy and complicated. So, we created a simple-to-use tools that can help make your life easier (and healthier). That's why there's www.myCigna.com—your online home for assessment and cost tools, plan management, provider directory, ID cards and much more.

Registration is easy:

1. Go to myCigna.com and select "Register."
2. Enter your personal details like name, address and date of birth.
3. Confirm your identity with secure information like your Cigna ID, social security number or complete a security questionnaire. This will make sure only you can access your information.
4. Create a user ID and password.
5. Review and submit.

Cigna One Guide

The **Cigna One Guide**® service can help you make smarter, more informed choices and get the most from your plan. Your One Guide personal support, tools and reminders can help you stay healthy and save money. Get in touch with the new Cigna One Guide team by phone, click to chat or via the enhanced **myCigna app**.

The **Cigna One Guide**® team will help you every step of the way. Our personal support begins with making sure you select in-network providers and facilities and make the most of your current coverage. Call or click to chat with a personal guide any time.

Online and on the go – myCigna.com and myCigna Mobile App. Download your app now from the App Store℠ or Google Play™.

Discount Program - Healthy Rewards

Save money when you purchase health and wellness products and services for things such nutrition, fitness, vitamins, alternative medicine through the Cigna Healthy Rewards® program. Visit myCigna for online program information or call **1-800-870-3470**.

Wellness Coaching from your Personal Health Team

You have a team of health specialists – including individuals trained as nurses, coaches, nutritionists, clinicians and counselors – who will listen, understand your needs and help you find solutions, even when you are not sure where to begin.

Call today to connect with your dedicated coach!
1-877-459-6150

Omada®

Baltimore County Government is offering **Omada**®, a digital lifestyle change program designed to help you lose weight and build healthy habits that last.

Join today and get:

A professional health coach for tailored support and guidance

A connected scale to monitor progress (and keep for good)

An online community personalized to your interests

Weekly online lessons to educate and empower you

Baltimore County is offering Omada at no cost to employees and their adult dependents who are eligible for Omada and enrolled in a Cigna or Kaiser Permanente plan—a $650 value.

Take Omada's quick health screener to see if you're eligible:

omadahealth.com/baltimorecountymd

Confidential Health Assessment

At Cigna, your health matters. We're here to make your journey easier. We offer personalized support that meets you where you are, so we can help you get to where you need to be. When you complete the health assessment questions on **myCigna.com**, you answer simple questions about your health and the result is a personalized report of your overall health. It's quick, personal and it's confidential!

24 Hour Health Information Line

What do you do when your child spikes a fever in the middle of the night? Don't worry, wonder or wait — whenever there's a question about health just call **1-800-896-0948** to connect with a specialist trained as a nurse, 24 hours a day.

Kaiser Permanente Select HMO

Active Employees and non-Medicare Retirees

Kaiser Permanente is a Health Maintenance Organization (HMO) that provides members with a full range of medical care benefits including preventive care services. Members of Kaiser Permanente must select a Primary Care Physician (PCP) from the over 1,400 physicians who practices exclusively in the Kaiser Permanente member centers or from a network of almost 15,000 community physicians who practice in the District of Columbia and Maryland, including Howard and Baltimore counties. It is important that you choose a PCP when you enroll, as this doctor will act as your good-health advocate and coordinate your care.

Kaiser Permanente Physicians

For help in choosing a primary care physician, review the physicians listed in the Kaiser Permanente Provider Directory included with your enrollment information. Physicians are listed according to their specialty and the county in which they practice. You will find two lists of physicians – those who practice in the Kaiser Permanente medical centers and are part of the Mid-Atlantic Permanente Medical Group, and those who practice in the community and are part of our network.

The list of Kaiser Permanente physicians also includes where the physician went to school, where they did their residency, their board certification and if they speak any foreign languages. This information should help you select a physician that best matches the needs of you and your family.

You may select a PCP for yourself and each member of your family. You can opt to have a single physician for your entire family or choose a different physician for each family member. Your PCP will work with you to coordinate your care, referring you for specialty care as needed and act as your good health advocate, guiding you through the preventive care services aimed at keeping you healthy through all your stages of life.

If you do not choose a PCP on your own when you enroll, Kaiser Permanente will choose one for you – selecting a physician from a medical center located close to your home. If you decide that you do not like the PCP selected for you or the one you have chosen for yourself, you may change your physician for any reason at any time. To change your physician, simply contact the Kaiser Permanente member services department at **1-800-777-7902**.

Covered Preventive Care Services

Members will have no copay requirement for preventive care services. Those services include, but are not limited to, the following age and gender appropriate physical exams, screening tests and the corresponding explanation of the results:

- Routine physical examinations
- Well-woman exams — including pap smear and screening mammograms
- Well-child examinations
- Routine age-based immunizations
- Bone mass measurement to determine risk for osteoporosis
- Prostate cancer screening exams and routine screening Prostate Specific Antigen (PSA) tests
- Colorectal cancer screenings
- Cholesterol screening tests

Note: ***Non-preventive issues and services managed during a scheduled preventive visit or service can result in additional charges for those non-preventive services.***

What is not covered as preventive?

The exam, screening tests, or interpretations for the following is not considered preventive:

- Monitoring chronic disease or as follow-up tests once you have been diagnosed with a disease
- Testing for specific diseases for which you have been determined to be at high risk for contracting
- Travel consultations, immunizations, and vaccines

Prescription Benefits

Prescriptions are $12 for generic, $30 for brand name drugs, and $45 for brand-name non-formulary, if filled at a Kaiser Permanente medical center, or $15 for generic, $45 for brand drugs, and $60 for brand-name non-formulary for up to a 30-day supply if filled at a participating community pharmacy. A mail order program is also available, which allows you to receive up to a 90 day supply of maintenance drugs for two copays.

When you fill your prescriptions at a Kaiser Permanente Medical Center pharmacy, you will pay the smallest copay amount. Prescriptions can also be filled at participating community pharmacies, such as Giant, Safeway, Rite Aid, Target, Wal-Mart and K-Mart. Prescription copays are higher when filled at participating community pharmacies than when you obtain your drugs at a Kaiser Permanente medical center.

Members are also able to order prescription refills online through the members-only section of the Kaiser Permanente Web site, **www.kp.org.**

Kaiser Permanente Select HMO

Active Employees and non-Medicare Retirees (continued)

Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend a variety of the "Be Well" classes offered in the Kaiser Permanente medical centers. The list of classes offered is printed in the provider directory and include classes on such topics as asthma management for children, heart failure, pediatric weight management, prenatal care/breastfeeding, smoking cessation, managing high blood pressure and more.

Members can also access a number of online services that Kaiser Permanente offers to aid in weight management, smoking cessation and relaxation. At **www.kp.org/healthylifestyles**, members can learn how to balance weight management and physical fitness through individualized programs. They can create an individualized nutrition plan, a personalized stress management program based on their own sources and symptoms of stress, or a personal plan to help decrease dependency on cigarettes.

Other Plan Features

- When your dependent children age off your Kaiser Permanente plan, they can choose to continue to receive their care through Kaiser Permanente by enrolling on their own through the Kaiser Permanent for Individuals and Family plan. You can find more information on receiving this individual coverage online at **www.kp.org.**
- Kaiser Permanente offers discounted programs for alternative medical services – acupuncture, chiropractic and massage therapy are some examples of those services.
- Managed Mental Health Services are coordinated through the plan (contact **1-866-530-8778** for assistance).
- Kaiser Permanente offers discounts to members on new health club membership when they join through Choose Healthy. Just go to **www.kp.org/choosehealthy.**
- When you get your care and services at a Kaiser medical center, My Health Manager becomes your one stop shop online resource 24 hours a day, 7 days a week. Features include: Email your doctor, view most lab test results, refill most prescriptions, schedule, cancel, or review routine appointments and much more. Go to **www.kp.org/registernow** to get connected.
- Download the Kaiser Permanente mobile app at no cost from your preferred app site. Use the convenient features of My Health Manager right from your smartphone or other mobile device. If you're already registered on kp.org, you're all set to start using your Kaiser Permanente app. If not, you'll need to go **kp.org/registernow** to set up your account from a computer. Then use your new user ID and password to activate the app.

Kaiser Permanente Medical Centers and After Hours Services

- Kaiser Permanente medical centers have multiple specialties under the same roof. Most have primary care services, such as pediatrics, obstetrics/gynecology and internal medicine, and specialty care services in the same location.
- Most Kaiser Permanente medical centers also provide services including laboratory, radiology and pharmacy in a single convenient location.
- For specialty referrals from a Kaiser Permanente physician, the specialist is often available within the same medical center or another area Kaiser Permanente medical center.
- Kaiser Permanente maintains a 24-hour, 7-day/week Medical Advice help line that is staffed by registered nurses who are available to answer urgent as well as routine medical questions over the telephone.
- The South Baltimore County Medical Center in Halethorpe, offers urgent care 24/7, 365 days per year.
- You can see your doctor face-to-face—without visiting the office. You can have a video visit with your personal doctor from home, work, or while on the go. Mental health along with some specialties are also covered through video visits. Whether you want a future appointment or need to be seen right away, just visit kp.org or use our mobile app to schedule. You must be registered at kp.org to take advantage of this service. Not registered? Visit kp.org/register. You may also call Kaiser Permanente to schedule your video visit at 1-800-777-7904 (TTY 711).
- Coming in Q1 2022! Kaiser Permanente Hub-Timonium! Kaiser is opening a 221,795-square-foot center in Timonium housing a broad range of health services and will operate as a one-stop-shop for patients. In addition to primary care, 24-7 urgent care and pharmacy operations, the center will offer medical and surgical specialty care, including optometry, audiology, pain management and other specialties. The Timonium hub will also offer advanced imaging and a lab.

Medical Plan Options *(Active Employees and non-Medicare Retirees)*

Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Member services	1-800-896-0948	1-800-896-0948	1-800-896-0948	1-800-896-0948		1-800-777-7902
Group Number	3333726	3333726	3333726	3333726		1651
COST SHARING LIFETIME LIMITS						
Calendar Year Deductible	$0 Individual / $0 Family	$200 Individual / $400 Family	$300 Individual / $600 Family	$2,500 Individual / $5,000 Family	$5,000 Individual / $10,000 Family	N/A
Calendar Year Medical Out-of-Pocket Maximum	$1,100 Individual / $3,600 Family	$1,000 Individual / $2,000 Family	$1,500 Individual / $3,000 Family	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family	N/A
Calendar Year Prescription Out-of-Pocket Maximum	$5,500 Individual / $9,600 Family	$5,600 Individual / $11,200 Family	N/A	N/A	N/A	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
OUTPATIENT PRESCRIPTION DRUG BENEFIT						
Dispensed at Pharmacy*	$12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary (copays apply for each 34 day supply)	$12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary (copays apply for each 34 day supply)		RETAIL **after the annual deductible is met:** Generic: you pay 10% / Brand Formulary you pay 10% / Brand Non-Formulary you pay 10% (for each 34 day supply)		One copay for up to a 30 day supply. $12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary for Kaiser Facility / $15 Generic / $45 Brand Formulary / $60 Brand Non-Formulary at other network pharmacies
Mail Order – Maintenance Medications* Mail order copays do not apply to Specialty Medications.	$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary (you pay only 2 copays for each 102 day supply)	$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary (you pay only 2 copays for each 102 day supply)		RETAIL and HOME DELIVERY **after the annual deductible is met:** Generic: you pay 10% / Brand Formulary you pay 10% / Brand Non-Formulary you pay 10% (for each 102 day supply)		$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary for mail order refills. Up to 90 day supply for maintenance medications
***** If you receive a brand name medication when a generic is available, you will pay the cost difference between the generic and name brand plus your copay.						
PROFESSIONAL SERVICES						
Annual Adult Physical	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Gynecology Annual Office Visit	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Mammography Screening / PAP / PSA Testing (Routine)	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Well Child Visit	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Primary Care Office Visit	You pay $15 per visit	You pay $15 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies (waived to age 5)
Specialist Office Visit	You pay $25 per visit	You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Physical/Speech/Occupational Therapy Office Visit	You pay $25 per visit 40 days for each therapy per calendar year	You pay $25 per visit Unlimited days per calendar year for all therapies combined	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay – days/visits limits apply
Acupuncture	PCP $15 / Specialist $25 copay Unlimited days per calendar year	PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$15 copay per visit limited to 20 visits per calendar year
Chiropractic Office Visit	You pay $25 per visit Limited to 40 days per calendar year	You pay $25 per visit Unlimited days per calendar year	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$15 copay applies limited to 20 visits/year
Allergy Shots/Other Covered Injections	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% no deductible	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Allergy Serum/Testing	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% No deductible	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70%	$10 copay applies

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Plan Facts	Cigna Open Access Plus In Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Diagnostic Tests	PCP $15 / Specialist $25 copay	PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Test covered in full on same day as office visit; $10 copay applies unless on list of $0 copayment preventive screenings
Diagnostic Tests Performed by Lab or Other Testing Facility and Billed Separately from Office Visit	Independent X-ray or Lab Facility Outpatient Facility You pay 0% / Plan pays 100%	Independent X-ray or Lab Facility Outpatient Facility You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Approved tests covered in full
INPATIENT CARE HOSPITAL						
Room and Board Preauthorization REQUIRED if Elective	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Physician/Surgical Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Anesthesia Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Medical Consultations	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
ICU/CCU	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Maternity/Nursery/Birthing Center	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Global Maternity Professional Fees You pay 0% / Plan pays 100% Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100%	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Global Maternity Professional Fees You pay 5% / Plan pays 95% after the deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Skilled Nursing/Rehab Facility Care	You pay 0% / Plan pays 100% 100 days per calendar year	You pay 15% / Plan pays 85% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	You pay 25% / Plan pays 75% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized, 100 days/year
Dialysis/Radiation/Chemotherapy	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Hospice	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 5% / Plan pays 95% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Physical/Speech/Occupational Therapy	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
OUTPATIENT HOSPITAL SERVICES						
Surgical/Anesthesia Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% per visit after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Dialysis/Radiation/Chemotherapy – Physicians Office	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Dialysis/Radiation/Chemotherapy – Outpatient Facility	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Physical/Speech/Occupational Therapy	You pay $25 per visit 40 days for each therapy per calendar year	You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Outpatient Diagnostic Services	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies for office visit

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Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
MATERNITY/INFERTILITY SERVICES						
1st Prenatal Visit	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay
Pre- and Postnatal Care and Delivery	Global Maternity Professional Fees You pay 0% / Plan pays 100% Inpatient Facility $100 copay per admission You pay 0% / Plan pays 100%	Global Maternity Professional Fees You pay 5% / Plan pays 95% after deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Global Maternity Professional Fees You pay 25% / Plan pays 75% after deductible is met Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	Global Maternity Professional Fees You pay 10% / Plan pays 90% after deductible is met Inpatient Facility You pay 10% / Plan pays 90% after the deductible is met	Global Maternity Professional Fees You pay 30% / Plan pays 70% after deductible is met Inpatient Facility You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Routine Nursery Care	Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100%	Inpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Sterilization/Reverse Sterilization	Physician's Office Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility You pay 0% / Plan pays 100% Excludes reversal of sterilization	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Includes reversal of sterilization	You pay 25% / Plan pays 75% after the deductible is met Includes reversal of sterilization	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies, reversal not covered
Elective Abortions in Inpatient or Outpatient Facility	Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility You pay 0% /Plan pays 100%	Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility / Outpatient Facility You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies in outpatient setting
Artificial Insemination (AI)	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% / Plan pays 75% after the deductible is met Unlimited dollar maximum on all infertility	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered at 50% of non-member rate when authorized
InVitro Fertilization (IVF)	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% / Plan pays 75% after the deductible is met Unlimited dollar maximum on all infertility	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	50% copay applies, limited to 3 attempts per live birth up to $100,000 per lifetime

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Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
MEDICAL EMERGENCIES						
Emergency Room	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full after $50 copay – copay waived if admitted
ER Follow-up visits	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Coordinate w/ PCP – Office visit copays apply
Urgent Care Facility	You pay $25 per visit – copay	You pay $25 per visit – copay	You pay $25 per visit – copay	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full after $25 copay – copay waived if admitted
MENTAL HEALTH / SUBSTANCE ABUSE						
Inpatient	$100 per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full
Outpatient	Physician office visit $25 per visit	Physician office visit $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 per visit for individual therapy $10 per visit for group therapy
OTHER SERVICES						
Ambulance	You pay 0% / Plan pays 100% (Includes Air Ambulance when medically necessary)	You pay 5% / Plan pays 95% after the deductible is met (Includes Air Ambulance when medically necessary)	You pay 5% / Plan pays 95% after the deductible is met (Includes Air Ambulance when medically necessary)	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full when authorized
Kidney, Cornea Bone Marrow Transplants, Heart, Heart-Lung, Lung, Pancreas, Liver Transplants	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility – Physician's Services You pay 0% / Plan pays 100%	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met (covered at 100% at LifeSource Center)	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Outpatient Cardiac Rehabilitation	Limited to 40 days per calendar year $15 PCP / $25 Specialist copay	Calendar year maximum: unlimited $15 PCP / $25 Specialist copay	You pay 25% / Plan pays 75% after deductible is met unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met, Limited to 40 days per calendar year	You pay 30% / Plan pays 70% after the deductible is met, Limited to 40 days per calendar year	$10 copay upon Medical Review Necessity (outpatient)
Hearing Aids	You pay 0% / Plan pays 100% of allowed benefit Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 0% / Plan pays 100% of allowed benefit Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 0% / Plan pays 100% Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 10% / Plan pays 90% after the deductible is met, Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 30% / Plan pays 70% after the deductible is met, Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	One hearing aid for each hearing impaired ear every 36 months up to a $1,000 maximum for adults and children
Durable Medical Equipment	You pay 0% / Plan pays 100% Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% after deductible Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% after deductible Unlimited Maximum per Calendar Year	You pay 10% / Plan pays 90% after the deductible is met, Unlimited Maximum per Calendar Year	You pay 30% / Plan pays 70% after the deductible is met, Unlimited Maximum per Calendar Year	Covered in full when authorized
Diabetic Supplies	Covered under DME or RX – copays may apply	Covered under DME or RX – copays may apply	Covered under DME or RX – copays may apply	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered at 80% – 20% copay

Dental Plan Options

Active Employees and Retirees

Cigna Dental Care Access (formerly Cigna DHMO)

The Cigna Dental Care Access (DHMO) plan requires you to select a general dentist for routine, preventive, diagnostic and emergency care. They will refer you to specialists as needed. No benefits are available if non-participating dentists are used.

For the most current information on participating dentists in your area, please visit www.cigna.com and click Find a Doctor, Dentist, or Facility. You may also call Cigna's automated dental office locator at **1-800-367-1037**.

To change your primary dentist, please contact Cigna Member Services for assistance.

Plan Highlights

Find a provider

To search for a dentist on www.Cigna.com, visit the site and click **"Find a Doctor, Dentist or Facility."** › Follow the prompts on screen and when asked to choose your plan, select **"CIGNA DENTAL CARE DHMO > Cigna Dental Care Access."**

- There is no deductible.
- There are no annual dollar maximums.
- There are no claim forms for you to file.
- All preventive care and some restorative care is available with zero copayments from you ($5 office visit copay applies).
- Complex procedures are available for low, pre-set patient charges that are published in the Patient Charge Schedule.

CareFirst BCBS Traditional Dental

The CareFirst BlueCross BlueShield Traditional Dental plan offers a national network of dental providers – 100,000 participating dentist locations nationwide. If you seek care from a CareFirst participating provider, the dentist cannot bill you the difference between their charge and the allowed amount. You are only responsible for deductibles and coinsurance. A non-participating provider will bill for any amount over the CareFirst allowed benefit. Some of the features include:

- No claim forms to file when you receive in-network care
- Each enrolled family member receives up to $2000 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst's Participating Providers file claims for you and cannot balance bill

CareFirst BCBS Preferred Dental PPO

The CareFirst BlueCross BlueShield Preferred Dental PPO plan offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined based upon whether you receive dental care from a preferred dentist. Some of the features include:

- Each enrolled family member receives up to $1,500 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst Preferred and Participating Providers file claims for you and cannot balance bill you
- Preventive care is available with no out-of-pocket expense if a CareFirst Preferred Provider is used
- The CareFirst Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined by whether or not you receive dental care from a preferred dentist.

In-Network Benefits

When you use a Preferred Provider, you receive the highest level of coverage with the least amount of out-of-pocket expense. In order to choose a preferred dentist, please refer to the Preferred Dental Provider directory at www.carefirst.com or contact member services at **1-866-891-2802**.

Out-of-Network Benefits

You may choose to use dentists outside of the network, but your costs may be higher. There are two types of out-of-network dentists:

- Participating dentists are not "preferred" dentists, but they have agreed to bill only up to the CareFirst BlueCross BlueShield allowed benefit amount, thus limiting your out-of-pocket expense.
- Non-participating dentists do not have an agreement with CareFirst BlueCross BlueShield. They may bill you their regular rates, which may increase your out-of-pocket expense. Members who receive care from non-participating dentists must pay for their services at the time the services are rendered and must file a claim for reimbursement directly to CareFirst BlueCross BlueShield.

Dental Benefits Summary

Active Employees and Retirees

	CareFirst BCBS Traditional Dental	CareFirst BCBS Preferred Dental PPO		Cigna Dental Care Access (Cigna DHMO)
Covered Service	Participating or Non-Participating*	In-Network (Preferred)	Out-of-Network	In- Network Only
Deductible per Calendar Year	$100 Per person $200 Per family	$100 Per person $200 Per family	$100 Per person $200 Per family	$0
Maximum Benefit per Calendar Year	$2000 Per person	$1500 Per person		Unlimited
	Plan Pays	**Plan Pays**		**Member Pays**
Preventative Care, Exams, Cleanings, X-Rays, Fluoride	100% when using a participating provider (Non-participating providers can bill the balance)	100%	80%	$5
Restorative Care, Fillings, Crowns, Root Canals	80% after deductible*	80% after deductible	60% after deductible	$5 to $225 Contact Cigna to obtain a detailed Patient Charge Schedule
Periodontal Services	50% for limited services after deductible; treatment plan required	80% for limited services after deductible; treatment plan required	60% for limited services after deductible; treatment plan required	$5 to $250 Contact Cigna to obtain a detailed Patient Charge Schedule
Implants, Prosthetic Services, Dentures, Bridgework,	50% after deductible; treatment plan required	50% after deductible; treatment plan required	30% after deductible; treatment plan required	$20 to $625 Contact Cigna to obtain a detailed Patient Charge Schedule
Emergency Care	No additional emergency provisions provided	No additional emergency provisions provided		$45 After regularly scheduled hours
Orthodontia Services	50% ($2000 lifetime maximum) For dependent children only up to age 19	50% after deductible ($1500 lifetime maximum) For dependent children only up to age 19	50% after deductible ($1000 lifetime maximum) For dependent children only up to age 19	Contact Cigna to obtain a detailed Patient Charge Schedule

*CareFirst payments based on allowed benefits. Non-participating providers can bill any amount over the CF allowed benefit.

CareFirst BlueCross BlueShield Vision

Active Employees and Retirees

Davis Vision administers your CareFirst BCBS Vision coverage. Davis Vision, a leading administrator of vision benefits programs throughout the U.S. and abroad, has a provider network consisting of 18,000 private practitioners, independent optometrists and ophthalmologists, opticians and point-of-service retail centers (Wal-Mart, Pearle, Target, Vision Works, etc.).

Effective 6/1/2021, the following Spectacle Lens Options have been added to the vision coverage
Polycarbonate Lenses for Children.....$0
Scratch Resistant Coating $20
Tinting $0
Oversized Lenses $0

Large Provider Network

Davis Vision has a comprehensive network of optometrists and ophthalmologists in Maryland and throughout the United States. However, while there are more providers from which to choose, there may be cases where your current eye care provider does not participate in this network. To find a provider near you, please visit **www.carefirst.com**. Click on **Providers & Facilities** tab, then click "Search for Doctor/Facility. Click "Search Now" then click "Continue as Guest". Select the type of provider you are looking for and follow prompts on screen. You can also call Davis Vision at **1-800-783-5602** (Client Code: 9002). Some offices participate for exams only and some provide significant discounts on lenses and frames. You will pay the least amount out-of-pocket by selecting a full-service office and choosing from the Davis tower of frames or Davis contact lens provider.

Benefits in Brief	Davis Provider You Pay	Out-of-Network You Pay
Routine Eye Exam (once every 12 months)	No copay	Plan reimburses up to $45*, you pay balance
Tower Collection Frames (Fashion)	$10	N/A
Tower Collection Frames (Upgrade)	$30	N/A
Non-Tower Frames	$100	Plan reimburses up to $45*, you pay balance
Single Vision Lenses Only	Included with frames	Plan reimburses up to $40*, you pay balance
Bifocal/Trifocal Lenses Only	Included with frames	Plan reimburses up to $60/$90*, you pay balance
Contact Lenses (in lieu of eyeglasses)	$10 copay on formulary or $75 Single/$95 Bifocal contact lens allowance towards provider supplied contacts	Plan reimburses up to $75/$95*, you pay balance (Single/Bifocal)
CareFirst	$100 In-network for non-collection frames	Plan reimburses up to $45

*You are responsible for all charges for services received out-of-network and must file a claim for reimbursement to Davis Vision.

** If your frames cost more than the allowance, you will pay 2 times the difference between the wholesale cost and the $20 allowance. For instance, if the wholesale cost of your frames is $50, your out-of-pocket costs will be determined as follows: $50 - $20 allowance = $30 x 2 $60 (your out-of-pocket cost for the frames)

$50 - $20 = $30 x 2 = $60

If you need glasses and contacts, your plan will only reimburse for one or the other every 24 months. It may benefit you to use your vision plan for the glasses and use **DavisVisionContacts.com** for replacement contacts. To compare your out-of-pocket cost, you may access **DavisVisionContacts.com** or call Davis Vision at **1-855-589-7911.**

Davis Providers

Independent providers with Tower Collection of frames
Independent providers will offer the exclusive Tower Collection.
You will pay:
- $10 Fashion frame with a gold tag
- $30 Designer or Premier frame with a red or blue tag
- One $20 wholesale allowance for non-Tower frames

Retailers with selection of frames
National retailers will offer their own selection of frames.
- You will be given a retail allowance of at least $40 (equates to a $20 wholesale allowance) which will be credited towards the retail cost of the frame

All in-network or participating Davis providers will offer the following services at no additional cost.
- One year breakage warranty on plan eyeglasses
- Plastic or glass lenses
- Oversized lenses

CareFirst BlueCross BlueShield Vision

Active Employees and Retirees

Out-of-Network Providers

Should you choose to visit an eye care professional **not in the Davis network,** you will still receive coverage; however, your **out-of-pocket costs will be higher** than if you had visited a network provider.

Note: ***Please be aware that non-Davis Vision providers will expect the entire payment up-front. You may then seek reimbursement by submitting a claim form to Davis Vision. You will be reimbursed up to your allowed amounts.***

Example Costs
You can save a significant amount of money if you use a Davis Vision provider as shown below.

	You Pay:
Example 1 Single vision with Davis Fashion Frame	$10
Example 2 Single vision with Davis Designer or Premier Frame	$30 ($10 material copay + $20 upgrade)
Example 3 Single vision with a Non-Davis Frame Retail Cost: $200 Wholesale Cost: $50	$60 (2 times the difference between the wholesale cost minus the $20 wholesale allowance) **$50 - $20 = $30 x 2 = $60**

BlueVision Discounted Rates on Special Services

In addition to your standard eye glass coverage, BlueVision also offers discounts or pre-negotiated fees for additional options.

- **Laser Vision correction** – entitled to a discount of up to 25% off providers usual and customary charge or a 5% discount from the Laser center's advertised special at participating Davis providers.
- **Davis Vision Mail Order Replacement Contact Lens Program** – allows significant savings of up to 50% on replacement contact lenses. Davis Vision Contacts will guarantee the lowest price. You would simply call **1-855-589-7911** with a valid prescription for replacement contacts or additional boxes.
- **20% courtesy discount** at most Davis Vision participating offices towards the purchase of items not covered, such as a second pair of glasses.

Does Davis Vision offer same-day service?

There are Davis Vision network providers who have the ability to deliver your glasses within 24 hours, but the lens strength, material design and/or frame style may influence availability of same day services. Please ask your Davis Vision provider when your glasses will be available. For more information call Davis Vision at **1-800-783-5602**. Generally, eyeglasses will be available for dispensing within 5 business days of your order.

Tinting	$0
Standard Progressive Lenses	$50
Premium Progressive Lenses	$90 (Varilux™, Kodak™, Rodenstock™)
Scratch Resistant Coating	$20
Ultra-violet Coating	$12
Plastic Photosensitive Lenses	$65 (Transitions™)
Polycarbonate Lenses	$30 (Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescription ≥ +/- 6.00 diopter.

You will have the least amount to pay out-of-pocket when you use a full-service Davis office that carries the Davis tower of frames.

Flexible Spending Accounts
Active Employees Only

Baltimore County uses the services of Benefit Strategies LLC to administer our Flexible Spending Accounts. There are two types of FSA accounts: Health Care Flexible Spending Account (Health FSA) for your out-of-pocket medical, prescription, dental, vision and hearing expenses and Dependent Daycare Flexible Spending Account (Dependent Care FSA) for your expenses related to dependent day care such as after school child care.

Why enroll in an FSA?

- **Give yourself a raise! Increase your spendable income by reducing the amount you pay in taxes.** FSA participants save approximately $27 in taxes for every $100 they set aside in an FSA.
- **Easily budget for the cost of health care expenses.**

Understanding the Health FSA

Health FSA funds can be used for health care expenses incurred by:

- You, your spouse, and your dependents up to age 26

Eligible expenses include associated costs with medical, prescription, dental, orthodontia, vision and hearing services. Refer to Health FSA Eligible Expense List later in this guide for a list of common eligible items, or view an expanded list on benstrat.com.

Understanding the Dependent Care FSA

Dependent Care FSA funds can be used for dependent care expenses you incur so that you (and your spouse if married) can be gainfully employed or attend school full-time.

To be eligible, the dependent must be your tax dependent who is:

- Under the age of 13
- Age 13 or older if physically or mentally incapable of self-care and residing in your home at least half the year

Eligible Providers and Settings:

- Day care centers and nursery schools
- Summer day camps
- Before/After school programs
- Babysitters including nannies, inside or outside the home (Relatives must be over 19 and not able to be claimed on your federal tax return. Non-relatives can be under the age of 19).
- Adult day care centers

Ineligible expenses include kindergarten, private school tuition, educational classes, and overnight camps.

As funds accumulate in your Dependent Care account through payroll deductions, you can submit for reimbursement.

Dependent Care FSA compared to IRS Child Care Credit:

- In most cases, a combined family Adjusted Gross Income of $40,000 and higher will see a greater tax savings through a Dependent Care FSA than the IRS Child Care Credit. A Dependent Care FSA and IRS Child Care Credit Comparison Chart can be found at benstrat.com. Consult with a tax advisor for details on your particular tax situation.

Example of Tax Savings Through a FSA	Before Enrolling in a FSA	After Enrolling in a FSA
Annual Earnings	$36,000	$36,000
Annual FSA Election Amount	-0-	-$1,500
Taxable Income	$36,000	$34,500
Approximate taxes paid (27.65%)	-$9,954	$9,539
Annual tax savings/increase in spendable income by enrolling in an FSA:		$415

Flexible Spending Accounts
Active Employees Only

Here's how it works:

1. **Decide if you want to enroll in the Health FSA, the Dependent Care FSA, or both.**
2. **Determine how much you spend annually on health care and dependent care expenses. (January 1st through December 31st and the grace period January 1st through March 15th of the following year).** Use the Election Worksheet and Eligible Expenses handout or the Tax Savings Calculator on www.benstrat.com to help determine your expenses.

   Note: The maximum Healthcare election for the upcoming plan year is $2,750. The maximum Dependent Care election for the upcoming plan year is $5,000.

   Important: Because you are receiving pre-tax treatment on the FSA funds, IRS regulations require that funds be spent within the time frame your plan specifies or you lose access to them. Make a conservative election; only consider expenses you and your family expect to incur.
3. **Enroll online at www.baltimorecountymd.gov/mybenefits by entering the total amount of your election on the appropriate enrollment screen. Your biweekly deduction will be calculated for you based the remaining pay periods in the plan year.** This amount is payroll deducted each pay period on a pre-tax basis throughout the year. **You are required to re-enroll during open enrollment each year if you want to participate in one or both FSA plans for the new benefit year.**
4. **Access your FSA funds throughout the plan year to pay for eligible expenses.**
   - Use the FSA debit card
   - Submit for reimbursement through the quick and convenient reimbursement methods. Reimbursements are made payable to you, either by paper check or direct deposit.

Use It or Lose It Rule

The amount you elect in your FSA account(s) must be spent for qualified expenses you have during the plan year plus an additional 2½ month period after the plan year ends. **(January 1st through December 31st and the grace period January 1st through March 15th of the following year).** Claims for expenses incurred during the allowed period must be submitted for reimbursement no later than April 30th following the plan year.

Coverage upon Termination of Employment

Upon termination of employment, you may continue your Health Care FSA coverage under COBRA through the end of the plan year in which you terminate employment. This is important if you have money left in your Health Care FSA that you expect to use before the end of the plan year. Payments for your Health Care FSA made after termination are after-tax. If you do not elect COBRA you will only be eligible to be reimbursed for expenses with dates of services prior to your termination date.

Annual Enrollment Required

You are required to re-enroll during open enrollment each year if you want to participate in one or both FSA plans for the new benefit year. This applies even if you want to elect the same amount you have in the current plan year. If you do not enroll online during the Open Enrollment period, you will not be able to have an FSA in the new benefit year.

Flexible Spending Accounts
Active Employees

Using Your FSA Funds

Health FSA Funds: Your full election amount is available on the first day of the plan year.

Dependent Care FSA Funds: Your funds are available as they accumulate through payroll deductions.

The FSA Card

It may look like a typical debit or credit card, but the FSA card is a special benefits card pre-loaded with your full annual Health FSA election amount. You use the card to pay for IRS qualified expenses directly at the point of sale or when paying a bill. The card works in settings such as physician offices, dental and orthodontic offices, optometrists, pharmacies, chiropractors, urgent care centers, and hospitals*.

- Two identical cards are mailed to your home address and additional sets of cards can be ordered.
- The IRS requires you keep all original documentation** for purchases associated with the FSA debit card. Benefit Strategies may also request copies of your documentation to verify a debit card purchase.

**If you are enrolled in the Dependent Care FSA, the card can also be used in dependent care settings. Just remember that the card will only work for an amount that does not exceed the available balance in your Dependent Care FSA account on that day.*

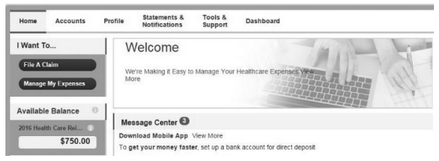
Electronic and Paper Reimbursement Methods – 3 to 5 day typical turnaround time

Reimbursements are made payable to you, either by paper check or direct deposit. All reimbursement methods require you to submit documentation.**

- Submit on-line through your secure account at benstrat.com
- Download the Benefit Strategies mobile application to submit through your mobile device
- Complete a paper claim form to submit via fax, secure email, or mail

***To be valid, documentation must include: date the expense was incurred, patient name (if applicable), amount of the expense after any insurance adjustment, provider name, service/product description.*

FSA Account Resources



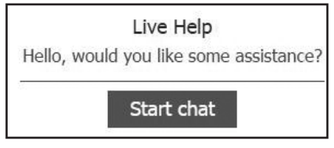
Your on-line account at benstrat.com

Through your secure on-line account at benstrat.com you can file for reimbursement, upload documentation, set up text message alerts, view claims history, account balances, filing deadlines, participate in Live Chats, and more.

Benefit Strategies Mobile Application

Download our mobile application for iPhone, Android and tablet devices to access account information on the go, including filing claims. Use your device's camera to photograph your documentation and upload it through the application!

Customer Relations Team



- **1-888-401-FLEX** (3539) or info@benstrat.com
- Monday - Thursday 8:00 AM - 6:00 PM ET; Friday 8:00 AM - 5:00 PM ET
- Automated system available through our toll free number at all times
- Please visit our website at benstrat.com

FSA Eligible Expense List
Active Employees

Health FSA Eligible Expenses

NEW: Over-The-Counter Medicines and Drugs no longer required a prescription!

Ace bandages
Acne treatments
Acupuncture
Allergy and sinus medicine
Antacids and digestive aids
Antibiotic ointments
Antifungal and anti-itch
Aspirin and other pain relievers
Asthma medicine
Athletic treatments
Band-aids
Blood pressure monitors
Canker and cold sore remedies
Chest rubs
Chiropractic care
Cholesterol meter test kit and supplies
Cold and flu medicine
Contact lenses
Contact lens cleaning solution
Co-insurance
Copays
Corn and callus removers
Cough medicine
CPAP machine
Crutches, canes and walkers
Deductibles
Dental care (routine and corrective)
Dentures
Diabetic monitors and supplies
Diaper rash ointments
Eye exams
Eye glasses
Eye related equipment
Fertility monitors
First aid kits
Gastrointestinal medication
Genetic testing*
Glucosamine
Group therapy
Hearing aids and batteries
Hearing care
Herbal medicine*
Hospitalization costs
Hypnosis – treatment of illness
Immunizations
Imaging scans
Incontinence supplies
Individual therapy
Laboratory fees
Lasik eye surgery
Laxatives
Lice treatments
Massage therapy*
Medical equipment
Medical monitoring and testing
New! Menstrual care products (tampons, pads, etc.)
Mileage to receive medical care
Motion and nausea medicine
Nutritional supplements*
Orthodontia
Orthopedic and surgical supports
Orthotics
Physical exams
Physical therapy
Physician services
Pregnancy tests
Prescription drugs
Psychoanalysis and mental health therapy
Reading glasses
Sleep aids
Smoking deterrents
Sunscreen (SPF30 and higher)
Thermometers
Toothache gels
Urological products
Vision care
Vitamins*
Wart removal treatment
Weight loss drugs and programs*
Wheelchairs and repairs

Visit benstrat.com for an expanded list of eligible expenses. If you have questions on what constitutes an FSA eligible expense, please contact our Customer Relations Team: 1-888-401-FLEX (3539) or info@benstrat.com.

Ineligible Expenses Examples

Cosmetic Surgery & Procedures
Health Club Dues
Insurance Premiums
Dental Hygiene Products

*Dual Use items and services are those that can be used for general health as well as to treat an illness or physical defect. If the item/service is prescribed to treat an illness or physical defect, a Physician Statement form needs to be submitted to Benefit Strategies for it to be FSA eligible. This form can be found on benstrat.com, or by contacting our Consumer Relations team. Dual Use items/services will not work with the Benefit Strategies Debit card. You will need to pay with another means and submit for reimbursement through one of our reimbursement methods. Remember to submit the Physician Statement, along with the purchase documentation.

Commuter Choice Parking and Transit Accounts

Active Employees only

Baltimore County has partnered with Benefit Strategies, LLC to offer eligible employees two additional benefit plans, Commuter Choice Parking and Transit Accounts. Intended for use by the employee only, these accounts help reduce the strain on your paycheck from work-related transportation expenses. Section 132 of the Internal Revenue Service (IRS) code allows you to use "pre-tax" dollars up to a monthly maximum for eligible mass transit and parking expenses. Benefit Strategies makes it easy for you to take advantage of this pre-tax benefit to reduce your taxable income and put more money in your pocket.

How it Works

There are two types of Commuter Choice accounts, parking and transit. You can enroll in one or both accounts—simply decide how much money you need for work-related mass transit or parking expenses each month. The monthly pre-tax maximum election for 2022 is $270 for each account. The amount within this maximum will be deducted from your paycheck each pay period, prior to Federal, State and FICA taxes being calculated. Your monthly election amount will continue throughout the plan year unless you decide to reduce, increase or stop your election. You pay less in taxes so you save money.

Parking Account

This account allows you to use pre-tax dollars to pay for work related parking expenses.

Using Your Parking Account Funds

When you enroll in a Parking Account, you will receive a FLEXEXPRESS card which looks and works like a typical debit card, making the process as easy as possible. There are no up-front payments, and charges are automatically deducted from your Parking Account balance.

If you have used your own funds to pay for parking you have a few options for requesting reimbursement:

- Download the Benefit Strategies app on your iPhone, Android and tablet devices and file for parking reimbursement.
- Log in to your Benefit Strategies Account and look for the link to file a claim.
  - If you have a receipt, you can scan and save it and then browse to upload it through the web site.
  - If you don't have a receipt, you will need to provide the following information: the month in which you parked; the name of the parking provider; the total amount to be reimbursed.
- Complete our Parking Benefit Plan Reimbursement Request Form. You can find this on **benstrat.com** or contact us at **1-888-401-FLEX (3539)** to have one sent to you.

Eligible Parking Expenses	Ineligible Parking Expenses
✓ Work-related parking costs incurred at or near your worksite	X Parking at an airport for air travel
✓ Work-related parking costs incurred at or near the place from which you commute to work by any means	X Parking expenses that are not work-related

Commuter Choice Parking and Transit Accounts

Active Employees only

Transit Account

This account allows you to use pre-tax dollars to pay for expenses incurred traveling to and from work. A transit pass is any pass, token, fare card, voucher or similar item entitling a person to mass transit transportation.

Using Your Transit Account Funds

When you enroll in the Transit Account, you will receive a FLEXEXPRESS card which looks and works like a typical debit card, making the process as easy as possible. You use the card to purchase a mass transit pass that best suits your needs and the amount will be deducted from your Transit Account. For example, if you will only be using mass transit for a portion of the month due to vacation, you can choose to purchase a pass option other than a monthly pass. You also choose when to purchase your pass. As long as you have sufficient funds in your Transit Account, you can purchase a pass at any point in the month. Your card can be used at transit vendors, including online transit vendors.

Note: No reimbursement requests can be submitted for Transit Accounts, participants must use their debit card.

Accessing your Commuter Choice Accounts

- Online—You will be sent information regarding your secure online portal. There you can file for parking reimbursement, set up text message alerts, view claims history, account balances, filing deadlines and more.
- Mobile App—Download our Benefit Strategies app on your iPhone, Android and tablet devices.

Contact Us

The automated system is available at all times by calling **1-888-401-FLEX (3539)**. Language translators are also available. You can also visit **www.benstrat.com** to chat with an online representative or email **info@benstrat.com** to learn more.

Eligible Transit Expenses	Ineligible Transit Expenses
✓ Work-related Bus, Light or Regional Tail, Streetcar, Trolley, Subway, Ferry, UberPOOL, Lyft Line, Vanpool	X Mileage and tolls
	X Taxis and limousines

New York Life Long-Term Disability Insurance (VLTD)

Active Employees Only

Important Note:

New York Life, America's largest mutual life insurer, announced the completion of the acquisition of, among other things, Cigna's group disability insurance business at the end of 2019. We are proud to continue the offering of VLTD benefits to our employees. It is a valued benefit. However, the benefit will be administered by and through New York Life. Any employee making a claim against their VLTD policy will do so through New York Life.

Eligiblity

- Full-time benefits eligible employees
- Part-time non-merit employees working 30+ hours/week
- Participation is voluntary
- 100% employee paid premium

How it Works

Employees who are absent from work for 90 consecutive days for an illness or injury may submit a claim for VLTD benefits. You are not required to exhaust your accrued leave before applying. If the claim is approved, 60% of your gross monthly base salary up to $7,500 will be paid when you become disabled and can't work for a period of time due to a covered illness or injury. Payments come directly to you or someone you designate and can be spent any way you like – just like you would use your paycheck.

Employee Premiums

Cigna Long Term Disability 100% Employee Paid		
	Monthly Rate/$100	Biweekly (26 Pays) Rate/$100
Employee	$0.632	$0.2917

Programs and Services

New York Life has a valuable website for you and your family to learn about disability, staying healthy at work, returning to work, and programs for healthy living.

Website: **https://www.newyorklife.com/group-benefitsolutions/employees/work-wellness.**

My Secure Advantage

My Secure Advantage is a full-service financial wellness offering that includes 30-days' prepaid expert money

coaching for various types of financial planning and challenges, such as identity theft and fraud resolution services, online tools for state-specific wills, and other important legal documents.
Website: **https://nylgbs.mysecureadvantage.com/**

When does coverage end?

LTD coverage ends on the last day of employment. The benefit is not portable. If an LTD claim is filed and approved prior to employment ending, benefit payments will continue according to the New York Life LTD policy.

How to enroll

Eligible employees may enroll in Voluntary Long- Term Disability by completing an online enrollment at **www.baltimorecountymd.gov/mybenefits**. New employees that would like to enroll may do so within the first 31 days of hire.

Contact Us

Call **1-888-842-4464** to speak with a New York Life customer service representative.
Please visit **myNYLGBS.com** to register your account and easily manage your claims in one place.

Voluntary Long-Term Disability Calculation Worksheet		
	Your Calculation	**Example**
Step 1: Monthly Salary (Up to $12,500)	_____	$3,000
Step 2: Divide by $100	_____	30
Step 3: Multiply by .2917 (26 pay rate) =	_____	$ 8.75/Pay

Life Insurance General Information

Life insurance offers financial protection for your loved ones in the event of your death. The County has partnered with Metlife to provide a range of competitive options for employees. This overview is provided for brief informational purposes only.

Eligibility

For active employees, life insurance is available for those working at least 30 hours per week. Spouse and child eligibility follow the rules of health insurance. (see page 4)

For those retires eligible to carry life insurance into retirement, only Basic Life and Legacy can be continued.

New Employees

All newly hired eligible employees will be automatically enrolled in Basic Life insurance the 1st of the month following their date of hire. New employees are required to waive life insurance through the Benefit Solver portal if they do not desire their automatic enrollment. Please note that once an employee has declined Basic Life coverage, they will need to provide Evidence of Insurability at the time of enrollment in the future.

New employees will have 31 days from their date of hire to enroll in Additional, Spouse, and/or Child Life insurance. All life insurance transactions are performed by the employee using the Benefit Solver portal. Visit **www.baltimorecountymd.gov/mybenefits** and click Log in to Benefit Solver.

Additional, Spouse and Child Life Insurance Active Employees only

Employees may enroll or change the amount of their Additional, Spouse and Child Life Insurance by completing an online enrollment at **www.baltimorecountymd.gov/mybenefits**. New employees that would like to enroll in these plans may do so within the first 31 days of hire without proof of Evidence of Insurability. During each annual open enrollment, you may elect an additional $10,000 of coverage without completing Evidence of lnsurability up to the maximum guaranteed issue amount for each line of coverage. All late applicants and requests for increases are subject to medical underwriting approval after providing Evidence of Insurability.

Current Employees

- Hired and eligible on or after 7/1/1997

  Eligible for prior to 1X salary in Basic Life(up to $200,00)

  Eligible for Additional, Spouse, and Child

  Can not be carried into retirement
- Hired and eligible prior to 7/1/1997

  Eligible for prior to 2X salary in Basic Life(up to $200,000)

  Eligible for Legacy, Additional, Spouse, and Child

  Basic and Legacy are eligible to be carried into retirement only if the employee will be drawing a pension immediately upon retirement.

Employee/Retiree Rate / County Subsidy

All Basic Life insurance an employee or retiree receives is mostly subsidized by Baltimore County based upon the below employee groups. The employee is responsible for a portion of the premium to be taken from each paycheck. Retirees will pay their portion from their monthly pension check. Basic Life insurance rates are based solely on policy amount. The total premium for Basic Life insurance is $.586 per $1,000 of coverage.

County Subsidy	Employee Group
90%	Supervisory, Management, and Confidential group employees, Elected Officials, Directors of Offices and Departments, Administrative Officer, BCFPE employees hired and eligible prior to July 1, 1997.
80%	IAF Firefighters, Professional Staff Nurses Association members, AFSCME employees, FOP, and any other employee hired and eligible prior to July 1, 1997.
80%	Eligible employees hired and eligible on or after July 1, 1997.

Life Insurance

Active Employees

The County recognizes that individuals have different needs and has provided you the opportunity to apply for the right amount of protection for you at very competitive group rates. Enrollment in Basic Life Insurance is a requirement for enrollment in Additional Life Insurance. In addition, enrollment in Additional Life is a requirement for enrollment in Child and Spouse Life Insurance.

Additional, Spouse and Child Life insurance cannot be carried into retirement; however, you may apply for conversion or portability. Refer to the plan features section for additional information.

Legacy Additional Life Insurance

Employees hired and eligible prior to July 1, 1997 may elect $10,000 or $20,000 at the rate of $1.25 per $1,000 of coverage. **This coverage may be carried into retirement**.

Additional Life Insurance

All eligible employees, including those hired prior to July 1, 1997, may elect Additional Life Insurance in any multiple of $10,000, starting at $10,000 up to $200,000 with rates based on your age. Evidence of insurability may be required based on the coverage you elect.

Your Additional Life Insurance coverage amount will reduce at the age of 65 in accordance with the Schedule of Insurance.

Age of Member Percentage	
65	65%
70	50%
75	35%

Spouse Life Insurance

If you elect Additional Life Insurance for yourself, you may also elect coverage for your spouse in $10,000 increments up to a maximum of 50% of the employee's Additional Life Insurance with rates based on the employee's age. Evidence of insurability may be required based on the coverage you elect. The employee is the beneficiary of the Spouse's Life Insurance.

Child Life Insurance

If you elect Additional Life Insurance for yourself, you may also elect $10,000 or $20,000 of coverage for your eligible child(ren) at the rate of $.10 per $1,000 of coverage regardless of the number of dependent children covered. The employee is the beneficiary of the child(ren) Life Insurance.

Please Note: Effective January 1, 2021 life insurance deductions began to be taken from every paycheck. They are no longer taken in full from the 1st pay of any given month. To determine the per pay amount, multiply the monthly amount by 12, then divide by 26.

Life Insurance Rates

Employee's Age	Employee Additional Life Insurance	Spouse Life Insurance
‹30	$ 0.041	$ 0.06
30-34	$ 0.056	$ 0.08
35-39	$ 0.064	$ 0.09
40-44	$ 0.071	$ 0.10
45-49	$ 0.106	$ 0.15
50-54	$ 0.163	$ 0.23
55-59	$ 0.304	$ 0.43
60-64	$ 0.466	$ 0.66
65-69	$ 0.898	$ 1.27
70+	$ 1.455	$ 2.06

Child Life Coverage	Child Life Monthly Deduction
$10,000	$1.00
$20,000	$2.00

Additional Life Insurance Calculation Worksheet		Your Calculation	Example Calculation (Age 40)
Step 1: Amount Elected	Line 1	_____	$200,000
Step 2: Line 1 divided by $1,000 = Line 2	Line 2	_____	200
Step 3: Select your rate from the table above	Line 3	_____	.071
Step 4: Line 2 multiplied by line 3	Line 4	_____	$14.20/month

Life Insurance

Active Employee Plan Features

All services mentioned are included at no additional cost to you. For any additional information regarding these services, call MetLife at **1-800-GET-MET8 or 1-800-438-6388**

Grief Counseling: Provides you and your dependents up to five face-to-face counseling sessions per event with a professional grief counselor to help cope with a loss, major life event or a serious medical condition. For additional information call **1-888-319-7819**.

Travel Assistance: Traveling with peace of mind. Access to medical, travel, and concierge services - 24 hours a day, 365 days a year when traveling internationally or domestically. For additional information call **1-800-454-3679**.

Accelerated Death Benefit: If you become terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months, you may have the right to receive a portion of your insurance as an accelerated benefit within your lifetime. You must apply and may receive up to 80% of your insurance.

Portability: If your coverage ends because your employment terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly.

Life Insurance Conversion Right: *Employees hired on/after July 1, 1997 are not eligible to continue their life insurance upon retirement except under Individual Conversion rights. You must apply and begin paying for your conversion coverage within 31 days of your coverage end date. Please contact the Insurance Division for more information.

Will Preparation Services: Offers you and your spouse face-to-face meetings with an attorney to prepare a will, living will or power of attorney for you and your spouse. Included with Additional Life Insurance Only.

MetLife Estate Resolution Services: Estate representatives and beneficiaries may receive face-to-face legal representation with probating your estate and your spouse's/domestic partner's estate. Beneficiaries can also consult a participating plan attorney for general questions about the probate process. Included with Additional Life Insurance Only.

Current Retirees

All premiums for life insurance carried into retirement are taken one time per month, deducted from a retiree's pension check.

Basic life insurance is subsidized into retirement at the same rate it was prior to an employee's retirement. Legacy plans, however, are paid in full by the retiree.

The amount a retiree is currently receiving in life insurance will not decrease based upon that retiree reaching any certain age. Furthermore, Baltimore County does not currently age-band retiree life insurance rates. Retirees pay the same rates per thousand of coverage for Basic Life insurance as active employees.

Current retirees with life insurance are not able to increase the amount of life insurance they are receiving through Baltimore County. They may, however, waive their life insurance policy at any time. Once waived, that particular retiree is no longer eligible for retiree life insurance and the policy can not be re-elected.

Retirees can quickly and easily designate and/or change their life insurance beneficiary through the Benefit Solver portal. Please see page 42 for online instructions.

For any retiree that is unable to designate online, please contact the Insurance Division.

How Do I Change My Life Insurance Beneficiary?

It is very important that you update your beneficiary designations as your life situation changes (e.g., marriage, divorce, death, birth of a child, etc.) to ensure that your life insurance proceeds are paid to the appropriate person(s). ***A change in your life insurance beneficiary election does not change your pension beneficiary designation; they are separate elections and must be updated separately.***

You may designate or update your life insurance beneficiary information quickly and easily at **www.baltimorecountymd.gov/mybenefits**.

- Click on green "Log In To Benefit Solver" button prior to logging into ESS.
- If you have not already created an online account, simply click "Register" and follow the instructions to create your account with MetLife.
- To begin the Beneficiary designation process, select "Change My Benefits", "Basic Info", "Change of Beneficiary (Use Today's Date)".
- If you have any questions about MetLife's web site or need additional assistance, contact the Baltimore County Insurance Division at 410-887-2568

Your Life Insurance will be paid to the beneficiary(ies) named. You may select a person(s), your estate, or an organization, such as a charity, as your beneficiary(ies). You must designate a primary beneficiary and have the option of designating contingent beneficiaries. A primary beneficiary is the person(s) who will receive a benefit upon your death. A contingent beneficiary is the person(s) who will receive a benefit in the event that all of the designated primary beneficiaries are deceased at the time of your death. If you name two or more beneficiaries in a class (primary or contingent), two or more surviving beneficiaries will share equally, unless you provide for unequal shares.

Remember, this beneficiary change is limited to your County life insurance plans only. Other plans that you may have, including the ***Employee Retirement System and Deferred Compensation, require a separate beneficiary change.***

Deferred Compensation
Active Employees Only

Nationwide Retirement Solutions (NRS) currently administers the Deferred Compensation program.

What is Deferred Compensation and how can it benefit me?

Deferred compensation lets you defer a portion of your current earnings into an account for your retirement. When you do this, you reduce the amount of your income that's taxable now. So you're not only investing for tomorrow, you're postponing federal income taxes today.

How a little can mean a lot

The hypothetical compounding example below assumes a $50 contribution every other week. Assuming a 28% tax bracket, each paycheck is only reduced by $36. Total returns reflect accumulated account balances at the end of the indicated periods based on contributions during that time period and the assumed annual rates of return. Costs of investing and taxes due upon withdrawal were not included; if they had been, returns would have been lower.

Years	at 4%	at 6%	at 8%
5	$7,187	$7,554	$7,939
10	$15,930	$17,664	$19,605
15	$26,568	$31,193	$36,746
20	$39,510	$49,297	$61,931
25	$55,257	$73,252	$98,937

Because this is purely an illustration, your results may vary. It is not intended to serve as a projection or prediction of the results of any specific investment. It does not account for taxes that would be due upon withdrawal. However, it does offer a realistic example of how your retirement investments may grow through deferred compensation.

The amount you choose to contribute to your program will depend on your specific situation. There is no "one-size-fits-all" solution. Your strategy likely will involve contributing as much as you can on a regular basis. The strategy you choose will depend on many variables, including the amounts you might receive from your pension and Social Security, what your investments earn between now and the time you retire, and what kind of standard of living you want at retirement. Regardless of how much you can afford to contribute, there are huge benefits to joining the deferred compensation program sooner rather than later.

Participating is easy

Begin by enrolling in the Baltimore County Deferred Compensation Program. **Karis Cox**, your NRS Retirement Specialist, can get you started. Just call **443-934-3237**. You can also take advantage of several other services that will allow you to manage your retirement investments whenever and wherever you want:

- Visit **www.baltimorecountydc.com** to enroll, change your deferral allocation or current investment, and receive financial information and education.
- Contact a Direct Access Retirement Specialist between 8 a.m. and 11 p.m. EST at **1-877-NRS-FORU** (877-677-3678).
- Use the NRS automated telephone service anytime day or night to process an exchange or allocation change, and check your account balance: **1-877-NRS-FORU** (877-677-3678).

For more information

Contact **Karis Cox**, your local Retirement Specialist, at **443-934-3237** or email **coxk9@nationwide.com**.

Labor First Private Medicare Exchange

Medicare Retirees

Effective January 1, 2021, Labor First began administering Medical and Prescription benefits for Baltimore County Medicare eligible retirees, dependents and beneficiaries exclusively through the Baltimore County Retiree Private Medicare Exchange. The Baltimore County Insurance Division will continue to administer Dental, Vision and Life Insurance for Medicare Retirees.

Who is Labor First?

Labor First is a Retiree Benefit Administrator and Advocacy Company, not an insurance carrier, that specializes in retiree healthcare. Labor First is available to assist Medicare eligible retirees with not only reviewing and enrolling in available plan options, but they are a committed resource for our members throughout the life of the plan.

Why Labor First?

- **More Options and Better Value:** The plans available to you from Labor First have been designed to provide you with more options and better value without sacrificing quality or coverage. Premiums will be conveniently deducted from your Baltimore County Pension Check.
- **Sustainability over the Long Term:** The transition to the Private Medicare Exchange offers sustainability over the long term through an approach that allows Baltimore County to continue subsidizing your coverage. Baltimore County will continue to subsidize your medical and prescription premiums based on your date of retirement, type of retirement and years of service.
- **Retiree Advocacy and Support:** Labor First advocates go far beyond just enrolling members. Below are few of the services your dedicated advocates can assist with after your enrollment and throughout the plan year:
  - Claims, billing and payment support
  - Real time Physician and pharmacy assistance
  - Medical and Rx Prior Authorizations
  - Medication Look up
  - Card replacements

Have Questions?

Call a Labor First Retiree Advocate dedicated to Baltimore County at **410-431-2226** or Toll Free at **1-855-499-2656** for more information on enrollment and plan offerings.

Visit

www.laborfirst.com/bcg for video recorded health seminars designed to assist you in understanding more about your Medicare options with Baltimore County.

IMPORTANT NOTE

Labor First is not an insurance provider. Labor First is a Benefits Administrator. They administer the Medicare benefits Baltimore County offers. You will continue with Baltimore County insurance even though you are signing up through and being managed by Labor First.

Appendix I

BALTIMORE COUNTY GOVERNMENT NOTICE OF PRIVACY POLICY AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED IF YOU ARE COVERED BY BALTIMORE COUNTY HEALTH BENEFIT PLANS. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the following Benefit Plans sponsored by Baltimore County, Maryland:

Medical Benefit Plans

- Medical Plans
- Dental And Vision Plans
- EAP And Managed Mental Health Plans
- Health Care Flexible Spending Accounts (FSAs)

These plans are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we will refer to these plans as a single "Plan." Please note that Baltimore County provides personal and demographic information required to establish your eligibility in these plans and provides the funding for the plans. In instances where the use or disclosure of your medical information is required for purposes of treatment, payment or operation of our health plans, Baltimore County has assigned those responsibilities to Plan Administrators.

The Plans covered by this notice may share information with each other when required and as permitted under law. The amount of health information used or disclosed will be limited to the Minimum Necessary to provide or pay for medical care. The Plans may also contact you to provide appointment reminders or other health-related services.

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request, and will be posted on the website maintained by Baltimore County Government that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan Administrators are permitted to disclose your PHI for purposes of your medical treatment. Thus, they may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it is important for your treatment team to know your blood type, the Plan Administrators could disclose that PHI in order to allow you to receive effective treatment.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan Administrators receive a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan Administrators detailed information about the care they provided, so that they can

be paid for their services. The Plan Administrators may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), they may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan Administrators may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining insurance coverage.

Other Uses and Disclosures of Your PHI Not Requiring Authorization.

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan Administrators may disclose PHI to Baltimore County who is the Plan sponsor and maintains the benefit plans offered to its employees, retirees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the County's Insurance Division for purposes of enrollment and disenrollment, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or for similar programs that provide benefits for work-related injuries or illness.
- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan (or Plan Administrator) limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To choose how the Plan contacts you:** You have the right to ask that the Plan (or Plan Administrator) send you information at an alternative address or by an alternative means. The Plan (or Plan Administrator) must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its Administrators if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by one of the Plan Administrators, you may request, in writing, that the record be corrected or supplemented. The Plan or Plan Administrator will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its Administrator and/or not part of the Plan's or Administrator's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or Plan Administrator, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- To find out what disclosures have been made: For actions that occur on and after April 14, 2003 (the date of this notice) you have a right to request a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and/or its Plan Administrators, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will receive a response to your written request for such a list within 60 days after you make the request in writing. You may make one (1) request in any 12-month period at no cost to you. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.

- If you think the Plan or one of its Plan Administrators may have violated your privacy rights, or if you disagree with a decision made by the Plan or a Plan Administrator about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information, or to Submit a Complaint.

- If you want more information about Baltimore County's privacy practices with respect to your health plans and who is covered on your plans, contact the County Insurance Division at (410) 887-2568.
- If you want more information about the privacy practices of the County's Plan Administrators, contact them directly at the Member Services number on your Plan ID card. Additional contact information for the County's Plan Administrators can be found on the County's website.

Privacy Official.

Baltimore County's Office of Budget and Finance HIPAA Privacy Compliance Officer:

Rebecca Ellis
Health Insurance Administrator
400 Washington Ave, Rm 111
Towson, MD. 21204
410-887-2568

Effective Date.

The effective date of this Notice is: April 14, 2006.

CUT AT DASHED LINE

BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION

1- Applicant's Personal Information

Name		**Street**					
SSN (Last 4)		**City**		**State**		**Zip**	
DOB		**Primary Phone**		**Email**			

If Widow or Spouse is Applicant: _____ _____
Retiree Name Retiree SSN

To Be Completed by the Insurance Division	
Ben Eff Date:	DPOL:
Date of Event:	Retirement Date:
Benefit Basis:	Entity:
Years of Creditable Service:	
Completed by:	Date:

IMPORTANT – Please provide address for person(s) being removed:_____

2- Enrollment Type

Type of Event		Add Dependent(s)	Remove Dependent(s)
☐ New Applicant	☐ Loss of other coverage	☐ Marriage*	☐ Legal Separation / Divorce*
☐ Eligible for Medicare: ☐ Self ☐ Spouse	☐ Gain of other coverage	☐ Birth/Adoption of a Child*	☐ Child over qualifying age
☐ Retirement	☐ Open Enrollment	☐ Other (please explain)	☐ Other (please explain)

*** If adding or removing dependent(s), please attach documentation within 31 days of event *Please provide address for person(s) being removed**

3- Benefit Options

Non-Medicare Retirees / Spouses	Medicare Retirees / Spouses	Dental Plans	Vision Plan
☐ Cigna Open Access Plus (OAP – In and Out of Network)	☐ Cigna Medicare Surr- Medical Only ☐ Retiree ☐ Spouse	☐ CareFirst BCBS Traditional Dental	☐ CareFirst Davis Vision
☐ Cigna Open Access Plus In-Network Only (OAPIN)	☐ Cigna Medicare Surr- Rx Only ☐ Retiree ☐ Spouse	☐ CareFirst BCBS Preferred PPO	☐ Waive Coverage
☐ Kaiser Permanente Select HMO	☐ Kaiser Medicare Plan ☐ Retiree ☐ Spouse	☐ Cigna Dental HMO	
☐ Waive Coverage	☐ Waive Coverage	☐ Waive Coverage	
Coverage Level : ☐ IND ☐ Ret+Sp ☐ P/C ☐ FAM		Coverage Level : ☐ IND ☐ Ret+Sp ☐ P/C ☐ FAM	Coverage Level : ☐ IND ☐ Ret+Sp ☐ P/C ☐ FAM

4- Dependent(s) Being Added or Removed (Rem)

Name	Add	Rem	Relationship	Gender	Social Security #	Date of Birth	Disabled Y/ N	Primary Care Doctor (Kaiser ONLY)	Primary Care Dentist (CIGNA ONLY)
RETIREE			SELF						

5- Medicare Information (if applicable)

Are you eligible for Medicare? ☐ YES ☐ NO If yes, attach copy of Medicare card	If yes, Medicare No:	Part A Effective Date:	Part B Effective Date:
Spouse eligible? ☐ YES ☐ NO Child eligible? ☐ YES ☐ NO	If yes, Medicare No:	Part A Effective Date:	Part B Effective Date:

All information I have given on this application is true to the best of my knowledge. I agree to follow the Retiree guidelines and eligibility rules set forth in the Retiree enrollment guide.

_____ _____
Applicant Signature **Date**

Return to: Baltimore County Insurance Division
400 Washington Ave Room 111
Towson, MD 21204
FAX: 410-887-3820 PH: 410-887-2568

	Plan Name	Customer Service Number	Website
MEDICAL	Cigna Open Access Plus (OAP) Cigna Open Access Plus In-Network (OAPIN) Cigna High Deductible Health Plan (HDHP)	1-800-896-0948	www.myCigna.com
	Kaiser Permanente Select HMO/Prescription	1-800-777-7902	www.kp.org
RX	Cigna Pharmacy Prescription Coverage for Cigna OAP/OAPIN/HDHP	1-800-896-0948	www.myCigna.com
DENTAL	CareFirst BCBS Traditional Dental CareFirst BCBS Preferred Dental PPO	1-866-891-2802	www.carefirst.com
	Cigna Dental DHMO	1-800-896-0948	www.myCigna.com
MENTAL HEALTH	Cigna OAP/OAPIN/HDHP	1-800-896-0948	www.myCigna.com
	Kaiser Permanente Select HMO	1-866-530-8778	www.kp.org
EAP	Cigna Behavioral Health	1-888-431-4334	www.myCigna.com (password: baltimore)
VISION	CareFirst BCBS Davis Vision	1-800-783-5602	www.carefirst.com
PRE-TAX ACCOUNTS	Benefit Strategies, LLC Flexible Spending Accounts (FSA) Parking and Transit Accounts Health Savings Account (HSA)	1-888-401-FLEX (3539)	www.benstrat.com
LIFE INSURANCE	MetLife	410-887-2568	www.baltimorecountymd.gov/mybenefits
DEFERRED COMPENSATION	Nationwide Retirement Solutions Karis Cox	443-934-3237	www.baltimorecountydc.com
VLTD	New York Life Long-Term Disability	1-888-842-4464	www.myNYLGBS.com
LABOR FIRST	Labor First	410-431-2226	www.laborfirst.com/bcg

Baltimore County Office of Budget and Finance
Insurance Division
400 Washington Avenue, Towson, MD 21204

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